Coordination of Benefits and Third Party Liability (COB/TPL)
In Medicaid
2016
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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 - ).
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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:**

   a. Chapters are major subject groupings and are designated with Roman numerals.

   b. Sections discuss major topics within chapters and are designated with capital letters.

   c. Subsections discuss single topics within sections and are designated with numbers.

   d. Divisions discuss single topics within subsections and are designated with lower-case letters.

   e. The Table of Contents lists chapters, sections, subsections, and divisions, with page numbers.
**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.

f. The Index lists all topics in alphabetical order, with location identified by chapter, section, subsection, and division references.

g. 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.

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

- To ensure that Medicaid does not pay more than it needs to, and to help recover funds that have already been paid out, 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.

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 program. The statute 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.
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 & Medicare

Beneficiaries who have both Medicare and Medicaid are called “Dual Eligibles.”

There are several types of Dual Eligibles: Full Benefit Dual Eligibles (FBDE), Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualifying Individuals (QI), Qualified Disabled Working Individuals (QDWI), and QMB Plus & SLMB Plus (dual 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 Eligible.

When Do COB/TPL Activities Take Place?

- Identification of third parties: when Medicaid eligibility is granted or shortly thereafter.
- “Cost avoidance” (requiring providers to use health insurance before billing Medicaid): before Medicaid pays a claim.
- COB (requiring cost avoidance before billing Medicaid for any remaining balance after insurance payment): when Medicaid pays a claim.
- “Pay & Chase” (The third party resource isn’t known when the claim comes to Medicaid, or the claim is for prenatal or preventive pediatric care, 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 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
- Section 4.22, TPL
- Supplement 1 to Attachment 4.19-B, Medicare Cost-Sharing Payment Methodologies

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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.¹

Federal matching funds are not available for Medicaid payments if:²
- 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
- A private insurer would have been obligated to pay for the service, except that its insurance contract limits or excludes payments if the individual is eligible for

¹ 42 CFR § 433.140(b).
² 42 CFR § 433.140(a).
Medicaid, since states should prohibit private insurers from discriminating against Medicaid beneficiaries

- 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.\(^3\)

3 42 CFR § 433.140(c).

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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.4

- 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 individual who:5
  - 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.

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4 Social Security Act § 1902(a)(45); Social Security Act § 1912.
5 42 CFR § 433.148.
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.

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 not assign their rights to Medicare.

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.\(^6\)

For Supplemental Security Income beneficiaries in some 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.

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\(^6\) 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 for a service if there are no other liable third party payers. 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.” Social Security Act § 1902(a)(25). 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), 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.

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])

Since Medicaid is generally the payer of last resort, it will not pay claims for services that third parties are obligated to cover. 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

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7 Social Security Act § 1902(a)(25).
9 42 CFR § 433.136.
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.

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, \(^{10}\)
- Parts B and C of the Individuals with Disabilities Education Act (IDEA), \(^{11}\)
- Ryan White Program, \(^{12}\)
- Indian Health Services, \(^{13}\)
- Women, Infants, and Children Program, \(^{14}\)
- Veteran’s benefits, for emergency treatment provided to certain veterans in a non-VA facility, \(^{15}\)
- Veteran’s benefits for state nursing home per diem payments, \(^{16}\)
- State health agencies, \(^{17}\)
- State vocational rehabilitation agencies, and\(^{18}\)
- Grantees under Title V of the Social Security Act (Maternal and Child Health Service Block Grant). \(^{19}\)

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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11 Social Security Act § 1903(c)
12 42 U.S.C. §§300ff et seq.
13 See Social Security Act § 1905(b)
17 Social Security Act § 1902(a)(11).
18 Social Security Act § 1902(a)(11).
19 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).
- Purpose. 42 U.S.C. §5300ff et seq.
A. State Plan Requirements

1. Required Elements in State Plan

State Plans must include specific information and assurances related to COB/TPL. The following sections of the Medicaid State Plan address TPL, liens and estate recovery, and Medicare cost-sharing payment methodologies for dual eligible beneficiaries:

- **TPL:** In Section 4.22, 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.

- **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.

- **Medicaid’s methodology for paying Medicare cost sharing for dual 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 eligible 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.

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20 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.21 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.

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

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<td>Social Security Act § 1902(a)(25)(I)</td>
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<tr>
<td>State Plan Requirements. 42 CFR § 433.137.</td>
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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:\n
- 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.

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.

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- **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.

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 DEE, CAHPG.

### 3. Exchanging Data with Other State 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:

- **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.

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23 42 CFR § 433.138.
- **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.

### 4. Diagnosis and Trauma Code Edits

**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.

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. Effective July 5, 2016, CMS no longer specifies codes for follow up or reviews and approves SMAs’ exemption of specific codes from trauma code editing. 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
- 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 must develop and submit a TPL Action Plan to the CMS RO. The action plan must specify how the SMA will do the following:

- 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

The TPL Action Plan should be updated as necessary to maintain currency with the SMA’s COB/TPL practices. If a SMA establishes new or revised TPL policies, procedures, and technologies that require CMS approval, the SMA should update its TPL Action Plan when it receives approval, and should 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.

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.

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24 42 CFR § 433.138(k).
25 42 CFR § 433.138(l).
References

Statutes & Regulations

- Social Security Act § 1902(a)(25)
- Definitions 42 CFR § 433.136.
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.\(^\text{26}\) 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. 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 30 days from the date of service without receiving payment before billing Medicaid.\(^\text{27}\) 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.

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\(^\text{26}\) 42 CFR § 433.139(b)(1).

\(^\text{27}\) 42 CFR § 433.139(b)(3)(ii).
- **Prenatal and Preventive Pediatric Services.** SMAs must pay and chase for claims for prenatal care and preventive pediatric services (including EPSDT).²⁸

- **Labor & Delivery and Postpartum Care.** SMAs may pay and chase for claims for labor and delivery and postpartum care (but not for inpatient hospital costs associated with labor and delivery).²⁹

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 obstetricians submit one bill for all prenatal and labor and delivery services. Even if an SMA does not ordinarily pay and chase claims for labor and delivery, it will have the option to pay and chase for the entire bundled claim, to ensure it complies with the requirements to pay and chase claims for prenatal services.

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.

### 3. Suspension or Termination of Recovery Efforts

²⁸ 42 CFR § 433.139(b)(3).
²⁹ 42 CFR § 433.139(b)(2).
**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. 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:

- 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. 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**. The request must document that meeting a requirement is not cost-effective. **SMAs** may submit, for example, documentation related to the 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

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30 42 CFR § 433.139(f).
31 42 CFR § 433.139(f).
32 42 CFR § 433.139(e).
33 42 CFR § 433.139(e).
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 October 2014, there were no currently approved cost-avoidance waivers.

References

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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 COB/TPL. General information about the process of obtaining medical child support is provided below. Detailed questions should be directed to the DEE, 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.34

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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34 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. The incentive payment must be 15 percent of the amount collected and be made from the federal share of the total amount collected. 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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35 42 CFR § 433.153(a)
36 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:37

- **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 CFR § 433.153.
- Distribution of Collections. 42 CFR § 433.154.

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37 42 CFR § 433.154.
E. Dual Eligibles

1. Introduction: Medicare and Medicaid Coverage for Dual 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 “dual eligibles.”

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 disabled individuals) 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.

3. Types of Dual Eligibles

An individual may qualify for help from Medicaid to pay some Medicare costs or for additional Medicaid benefits, depending on his income and resources.

Full Benefit Dual Eligibles (FBDE). An individual who is eligible for Medicaid either categorically or through optional coverage groups such as the medically needy (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).

Dual eligibles 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 Medicaid benefits, 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 who lost Medicare Part A benefits because they returned to work, but who is eligible to enroll in and purchase Medicare Part A. The individual’s income may not exceed 200 percent of the FPL and resources may not exceed three times the SSI limit.

Questions about Medicaid coverage groups for dual eligibles should be directed to DEE, CAHPG.

### 4. Medicaid Coverage for Medicare Costs

Medicare cost-sharing benefits include Medicare Parts A and B premiums, coinsurance, deductibles, and copayment amounts.
Medicaid will cover a different set of these benefits for each category of duals, as described in the chart below:

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<tr>
<th>Category</th>
<th>Medicare Part A Premiums</th>
<th>Medicare Part B Premiums</th>
<th>Medicare Cost Sharing (Except Part D)</th>
<th>Other Medicaid Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Part A</td>
<td>Part B</td>
</tr>
<tr>
<td>QMB Only</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>QMB Plus</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>SLMB Only</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLMB Plus</td>
<td>✓</td>
<td>✓</td>
<td>✓*</td>
<td>✓</td>
</tr>
<tr>
<td>QI</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>QDWI</td>
<td>✓</td>
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<td></td>
<td></td>
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<tr>
<td>FBDE</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

✓* SMAs may choose to cover Medicare Cost Sharing for all Medicare-covered services (Part A and/or Part B, as indicated above) or only for those services covered in the State Plan for Medicaid beneficiaries who don’t have Medicare coverage.

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 dual eligibles 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 dual eligible’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.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB Only</td>
<td>Optional</td>
<td>Not allowed</td>
<td>Required</td>
</tr>
<tr>
<td>QMB Plus</td>
<td>Optional</td>
<td>Optional</td>
<td>Required</td>
</tr>
<tr>
<td>SLMB Only</td>
<td>Not allowed</td>
<td>Not allowed</td>
<td>Not allowed</td>
</tr>
<tr>
<td>SLMB Plus</td>
<td>Not allowed</td>
<td>Optional</td>
<td>Conditional*</td>
</tr>
<tr>
<td>QI</td>
<td>Not allowed</td>
<td>Not allowed</td>
<td>Not allowed</td>
</tr>
<tr>
<td>QDWI</td>
<td>Not allowed</td>
<td>Not allowed</td>
<td>Not allowed</td>
</tr>
<tr>
<td>FBDE</td>
<td>Not allowed</td>
<td>Optional</td>
<td>Conditional</td>
</tr>
</tbody>
</table>

* SMAs do not generally cover Medicare cost sharing 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 pays more than the Medicare payment amount. In these circumstances, the SMA must reimburse 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 (including Medicare Part C) liability. 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 dual eligibles, Medicare is generally liable for claims, and thus SMAs are required to cost-avoid claims for dual eligibles. 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 dual eligibles 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.38

Claims for cost sharing submitted by providers who have received primary payment from Medicare are referred to as “crossover claims,” since they usually crossover from Medicare to the SMAs, after Medicare has made the primary payment.

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.39 For those FBDEs who do not qualify as QMBs, SMAs have the option to cover cost sharing for all Medicare-covered services or only for Medicaid-covered services.

38 Social Security Act § 1935(d).
39 Social Security Act § 1902(a)(10)(E); see Social Security Act § 1905(p)(1) for the definition of qualified Medicare beneficiary.
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.

<table>
<thead>
<tr>
<th>Cost Sharing Coverage and Payment Amounts for Medicare/Medicaid-Covered and Medicare-Only Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Covered by Medicare and Medicaid</td>
</tr>
<tr>
<td>Cost Sharing Covered</td>
</tr>
<tr>
<td>Required for QMBs, QMB Plus, SLMB Plus and FBDEs</td>
</tr>
<tr>
<td>Payment Amount</td>
</tr>
<tr>
<td>Total payment may be capped at the SMA’s choice of:</td>
</tr>
<tr>
<td>- State Plan rate</td>
</tr>
<tr>
<td>- Medicare rate</td>
</tr>
<tr>
<td>- Some amount in between Medicaid and Medicare rates (i.e., a negotiated rate), as approved by CMS</td>
</tr>
<tr>
<td>Service Only Covered by Medicare</td>
</tr>
<tr>
<td>Required for QMBs and QMB Plus; optional for FBDEs and SLMB Plus</td>
</tr>
<tr>
<td>Total payment capped at the SMA’s choice of</td>
</tr>
<tr>
<td>- “Reasonable limit” (i.e., negotiated rate) approved by CMS</td>
</tr>
<tr>
<td>- Medicare rate</td>
</tr>
</tbody>
</table>

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 received from Medicare exceeds the State Plan rate. The SMA will issue a Remittance Advice (RA) reflecting $0 payment to the provider.

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 duals 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 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-level cost sharing), even if the SMA’s payment is less than the total amount of the Medicare deductibles and coinsurance.\textsuperscript{40} Because of this prohibition on balance billing, the provider may receive less total payment for services rendered to QMBs than to other Medicare beneficiaries.

To ensure that QMBs are not balance-billed for additional 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 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

\textsuperscript{40} Social Security Act § 1902(n)(3).
limited purpose of billing for Medicare cost-sharing amounts, the SMA must still follow the Medicaid/CHIP provider screening and enrollment rules.41

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.42 Medicare regulations allow for the following exceptions to the one-year time period for filing claims:

- **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.

- **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.

f. Special Considerations: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for Certain Dual Eligibles

To improve efficiency in the Medicare program, Medicare is using a competitive bidding program for DMEPOS for Original Medicare (i.e., fee-for-service) beneficiaries only. In

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41 Social Security Act § 1902(a)(77) and (kk).
42 Social Security Act §§ 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B); 42 C.F.R. § 424.44
43 42 CFR § 424.44(b).
areas of the country where the competitive bidding program is in effect, Medicare Part A and Part B will only pay for competitively bid DMEPOS services provided by certain contracted providers. Exceptions to this requirement include:

- **Items Outside of Competitive Bidding.** Some DMEPOS services are outside the competitive bidding program, and Medicare will pay for non-competitively bid items supplied by non-contracted providers.

- **Grandfathered Suppliers.** If a non-contracted provider was renting an item to a Medicare beneficiary who lives in an area covered by the competitive bidding program at the time the competitive bidding program began in that area, the non-contracted provider can continue to rent the item as a “grandfathered supplier.”

Medicare also implemented a national mail-order program for diabetic supplies. Any individual covered under Medicare Part A and Part B who wants to receive diabetic supplies by mail must use the mail order provider.

The competitive bidding program has several implications for Original Medicare-enrolled dual eligibles. All dual eligibles enrolled in Part A and Part B who live in an area covered by the competitive bidding program must receive DMEPOS services from a contracted provider, unless an exception applies. This requirement applies to duals enrolled in a Medicaid managed care organization (MCO), if the state Medicaid program pays the MCO a capitation rate that includes MCO payment of Medicare cost-sharing amounts.

Note that in some cases, the contracted provider will be out-of-state. Since the DMEPOS services are furnished in-state, the provisions of federal regulations that would normally limit Medicaid payment to out-of-state providers do not apply.\(^4\)

\(^4\) 42 CFR § 431.52.
Medicaid coverage for DMEPOS for dual eligibles is described in the table below:

<table>
<thead>
<tr>
<th>Category</th>
<th>Medicaid Coverage for DMEPOS for Dual Eligibles</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB Only</td>
<td>Medicaid pays Medicare cost-sharing amounts only. If Medicare denies payment for the service, Medicaid will not pay.</td>
</tr>
</tbody>
</table>
| QMB Plus | 1. Medicaid pays Medicare cost-sharing amounts for Medicare-covered DMEPOS.  
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. |
| SLMB Only | Medicaid does not pay Medicare cost-sharing amounts, except Part B premiums. |
| SLMB Plus | 1. Medicaid pays Medicare cost-sharing amounts for services as specified in the State Plan.  
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. |
| FBDE | 1. Medicaid pays Medicare cost-sharing amounts for services as specified in the State Plan.  
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. |

**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 related to dual eligibles 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 dual eligible 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. Note, however, that 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 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 Retro 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 performs the newly eligible transition (NET) 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.45

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**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)(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

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45 45 CFR § 162.1901 and § 162.1902.
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.  

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.

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 of claims and then seek recovery—“pay and chase” in the same circumstances as the **SMA** is required to do so.*

46 42 CFR § 438.6.
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 beneficiary’s third party coverage is a commercial MCO, the SMA—whether through fee-for-service or managed care—will not pay for services if the beneficiary received care from a provider who was out of the commercial plan’s network. 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.

### References

**Statutes & Regulations**

- Contracts Requirements. 42 CFR § 438.6.
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.
- 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.
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. 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.

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47 Social Security Act § 1917(a).
48 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 for costs of medical care all but a minimal amount of his income (reserved for personal needs); and (3) determined by the SMA that he cannot reasonably be expected to be discharged and return home. 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.

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

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49 Social Security Act § 1917(a)(1)-(2).
50 Social Security Act § 1917(a)(1)-(2).
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 an institution and returns to the home, since the lien is only permitted because the beneficiary was a permanent resident of the institution.51

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<th>References</th>
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<tbody>
<tr>
<td><strong>Statutes &amp; Regulations</strong></td>
</tr>
<tr>
<td>- Social Security Act § 1917(a)</td>
</tr>
</tbody>
</table>

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51 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.\(^{52}\)

- 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.\(^{53}\)

- 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*

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\(^{52}\) 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.

must 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. 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.

- 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. If, instead, the SMA elects to recover 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 services subject to recovery. 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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54 Social Security Act § 1917(b)(1)(C).
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).\(^{56}\)
- When the deceased beneficiary does not have a child who is under age 21 or blind or disabled, regardless of where the child lives.\(^{57}\)
- 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:\(^{58}\)
  - 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.\(^{59}\) An SMA’s hardship policy must be set out in its State Plan. SMAs have discretion in defining what constitutes an undue hardship. Some common situations that may cause undue hardship if the SMAs enforced the Medicaid estate recovery claim include:
  - 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.

\(^{56}\) Social Security Act § 1917(b)(2)(A).
\(^{57}\) Social Security Act § 1917(b)(2)(A).
\(^{58}\) Social Security Act § 1917(b)(2)(B).
\(^{59}\) Social Security Act § 1917(b)(3).
An **SMA** may conclude that there is no undue hardship if the beneficiary created the hardship by resorting to estate-planning methods under which the deceased beneficiary illegally divested assets in order to avoid estate recovery.

### 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.”

  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, however, is passed to another person. After the user dies, the property passes to the other person. For example, an individual could deed a house to someone, but retain a life estate interest that would allow him/her to live there until death. Under common law, that person has no interest at the time of death, since the life estate ceases to exist when the person dies and the full rights to the property are transferred to the other owner.

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60 Social Security Act § 1917(b)(4)(B).
Although common law holds that a person 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;\(^{61}\)
  - 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 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

\(^{61}\) Social Security Act § 1917(b)(3)(B).
exemption of the asset based on the source of the purchasing funds as a reparation payment.62

References

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<td>Social Security Act § 1917(b).</td>
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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 United States Supreme Court held that the federal Medicaid statute only permits recovery for medical assistance from the portion of a liability settlement attributed to medical items and services. The Court further held that if the state attempted to recover from more than the portion of a settlement that the parties allocated to medical items and services, it was a violation of the federal anti-lien statute. Finally, 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.

In 2013, Congress amended the Act to give states authority to recover from the full award, up to the total amount paid in Medicaid services. Additionally, Congress gave
states authority to place liens on tort awards. (H.J. Res. 59-13, Bipartisan Budget Act of 2013, November 2013; changes effective October 1, 2014). However, in 2014, Congress delayed the implementation of these changes to the Act until October 1, 2016 (H.R. 4302, Protecting Access to Medicare Act of 2014, enacted April 1, 2014, as P.L. 113-93). In 2015, Congress enacted the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), as P.L. 114-10, delaying the implementation date again, to October 1, 2017.

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 any 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.

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.

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.

- **Compromising with the SMA’s Share.** Finally, SMAs can elect to give a portion of their share of the recovery to the beneficiary.

### 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 agree to be bound by a settlement that compensates the SMA for a reasonable estimate of 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 Dual 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 any of these third parties. 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 would otherwise have been paid to the beneficiary. But 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.
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. 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]).”

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.

References

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63 42 CFR § 433.136.
64 42 CFR § 433.136.
C. American Indians/Alaska Natives

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

1. Payer of Last Resort

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. SMAs will pay for medical expenses that would otherwise 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. 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.

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65 See Social Security Act § 1905(b).
66 Social Security Act § 1905(b).
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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 would generally be regarded as a source of TPL, thereby offsetting the amount Medicaid owes. A 2004 federal law, however, prohibits these per diem payments from being treated as a third party resource for the purposes of Medicaid TPL. Because of this law, the per diem payments from the VA may not be 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 are not eligible for coverage of emergency treatment at non-VA facilities if they are eligible for Medicaid. 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.

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<td>- Pub. L. No. 108-422, § 202</td>
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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. Data Matching

The DOD maintains the Defense Enrollment Eligibility Reporting System (DEERS), a robust database containing information about, among other things, individuals eligible for TRICARE.

To identify individuals eligible for both Medicaid and TRICARE, the DOD has established a process to match data with SMAs. The data match enables the DOD and SMAs to do the following:

- Identify Medicaid beneficiaries who may be eligible for TRICARE.
- Prevent fraud and abuse.
- Ensure that the appropriate agency is paying for health care services.

The data match process complies with HIPAA requirements.

2. 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.

3. 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).\(^{69}\)

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\(^{70}\) 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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<td>- Contracts for Medical and Dental Care: State and Local Preemption. 10 U.S.C. § 1103.</td>
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\(^{69}\) 10 U.S.C. § 1103.
\(^{70}\) 10 U.S.C. § 1101.
List of Statutory Provisions

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

- 10 U.S.C. § 1101  TRICARE-Timely Filing
- 10 U.S.C. § 1103  TRICARE Timely Filing
- 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**

- §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**

- §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)(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
§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 eligibles 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
| §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 |
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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
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Coordination of Benefits/ Third Party Liability (COB/TPL)

Overview

2016
COB/TPL Staff

CMCS/DEHPG
Division of Health Homes, PACE, and COB/TPL

Director: Carrie Smith
COB/TPL Team:
- Technical Director: Nancy Dieter
- Health Insurance Specialists:
  Cathy Sturgill, Ginger Boscas, Sara Rhoades
Topics

What’s COB/TPL and Why Is It Important?
Types of Third Parties
Coordination of Benefits (COB)
Third Party Liability (TPL)
Payer of Last Resort
Beneficiary Requirements
State COB/TPL Responsibilities
Identifying Third Parties
What is COB/TPL and Why Is It Important to Medicaid?

- The overall purpose of COB/TPL programs is to ensure that federal and state funds are not misspent for covered services to eligible Medicaid beneficiaries, when third parties exist that are legally liable to pay for those services.

- “Third party means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.” (42 CFR 433.136)
Types of Third Parties

Section 1902(a)(25)(A) of the Social Security Act (the Act) says “third party” includes health insurers and self-insured plans, group health plans and service benefit plans, managed care organizations, pharmacy benefit managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.
Types of Third Parties (Continued)

Third parties also include other federal programs (e.g., Medicare Parts A and B; TRICARE), Medicare Parts C and D (risk-bearing entities), Workers’ Compensation, indemnity plans that pay for medical services, and third party administrators and fiscal intermediaries, when health insurers delegate responsibility to them to make payments on their behalf.
Types of Third Parties (Continued): Liens and Estates

- Section 1917(a) of the Act allows states to place liens on the property of Medicaid beneficiaries in certain circumstances.

- Section 1917(b) of the Act requires states to make claims against the estates of deceased Medicaid beneficiaries in certain circumstances.

- Both actions establish liable third parties.
Coordination of Benefits (COB)

- Coordination of Benefits (COB) refers to the activities involved in determining Medicaid benefits when an enrollee has coverage through a third party resource that is, or may be, liable to pay for health care services.

- The Government Accountability Office (GAO) estimated 13.4 percent of Medicaid respondents to a U.S. Census Bureau survey in 2012 had other health coverage.
When third party benefits may be available at the time of service, Medicaid generally requires the Medicaid provider to bill third parties and obtain payment or a denial of liability before billing Medicaid for any remaining balance after third party payment.

Third parties pay to the limit of their liability.

COB supports Medicaid’s standard “cost avoidance” claims processing.
Third Party Liability (TPL)

- Third Party Liability (TPL) refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

- Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid Agency.
TPL (Continued)

- If third party payments aren’t available (ex., casualty/tort settlements, liens, estate claims), or coverage isn’t known, at the time of service, Medicaid will pay and attempt to recover from the third party at a later date.

- This is called “pay and chase” processing.
Pay and chase claims processing is required for prenatal services, preventive pediatric services, and services provided to a child whose health coverage is subject to state IV-D child support enforcement activities. (Sections 1902(a)(25)(E) and (F) of the Act; 42 CFR 433.139(b))
Medicaid’s Payer of Last Resort Status

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 program. The statute 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.
Payer of Last Resort Status: Programs Primary to Medicaid

Examples of programs that pay before Medicaid:

- Medicare Parts A and B (Title XVIII of the Act),
- CHAMPUS/ TRICARE (42 U.S.C. 1079 (J)),
- Vaccine Injury Compensation (P.L. 101-239),
- Public health programs administered by the U.S. Department of Health and Human Services (HRSA, SAMHSA or CDC [e.g. Hansen’s program (leprosy), Black Lung program], and
Examples of programs that pay before Medicaid:

- State or locally mandated programs for mental health or other medical arena (includes programs to provide primary and preventive care in schools, if specified in state law).
An exception to Medicaid’s payer of last resort status means Medicaid is the primary payer. Medicaid must pay before the following programs:

- Crime Victims Compensation (42 U.S.C.10602),
- Parts B & C of the Individuals with Disabilities Education Act (IDEA) for services in a child’s Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP) (20 U.S.C. 1400; and section 1903(c) of the Act),
Payer of Last Resort – Exceptions (Continued)

Medicaid must pay before:

- Ryan White HIV/AIDS Programs (P.L. 101-381),
- Indian Health (section 1905 (b) of the Act),
- Women, Infants and Children (WIC) (42 U.S.C. 1786),
- Older Americans Act Programs (P.L. 89-73), Federal Emergency Management Agency (FEMA) (P.L. 100-707), and
Payer of Last Resort – Exceptions Under Certain Conditions

Medicaid is primary payer to:

- State health agencies, state vocational rehabilitation agencies, Title V maternal and child health grantees (title V of the Act), and Crippled Children’s Service, when services are provided under arrangement with the state Medicaid agency (section 1902(a)(11) of the Act),
Veterans benefits—emergency treatment furnished to certain veterans in a non-VA facility (38 U.S.C. section 1725),

Veterans benefits—state nursing home per diem payments (38 U.S.C. section 1741), and
Public agencies or programs that have a general responsibility to ensure access to needed health care, including schools, public health agencies, and child protective services, except for instances of specific liability (examples: casualty/tort claims, employee health benefits, or when liability is specified in state law) (CMS State Medicaid Directors Letter 14-006, December 15, 2014).
TPL Requirements of Beneficiaries

Medicaid beneficiaries must:

- Assign their rights to payment from third parties to the Medicaid program (except Medicare beneficiaries),
- Agree to cooperate in establishing paternity and medical support, and
- Agree to cooperate with the state in identifying and pursuing third parties.
Good Cause Exceptions

A Medicaid applicant may establish good cause for not cooperating. (section 1912 of the Act; 42 CFR 433.145-147)

- The state Medicaid program determines if good cause exists, according to standards developed by the state.

- Determination must be made on a case-by-case basis and documented in the beneficiary’s case file.
State COB/TPL Responsibility

The state must:

- Make reasonable efforts to seek reimbursement from third parties who are legally liable to pay for services provided to Medicaid beneficiaries; and

- Have laws that:

  - Prohibit any health insurer from taking Medicaid beneficiary status into account in enrolling or making any payments for benefits,
State COB/TPL Responsibility
(Continued)

- Affirm that the state is considered to have acquired the Medicaid beneficiary’s rights to payment by any other party for health care items or services paid by Medicaid, and

- Require health insurers to:
  - Provide information to determine period and nature of coverage by a health insurer,
State COB/TPL Responsibility (Continued)

- Accept the state’s right of recovery and the assignment of the beneficiary’s rights,
- Respond to any state inquiry about claims within a period set in state law, and
- Agree not to deny a claim submitted by the state solely on the basis of procedural requirements.
State COB/TPL Activities

States must:

- Identify third parties;
- Maintain a TPL action plan, describing how they pursue third parties, and update it as necessary;
- Sanction providers who inappropriately collect from beneficiaries; and
- Cost avoid claims, except: prenatal and preventive pediatric services and services to a child whose insurance is subject to IV-D enforcement. (sections 1902(a)(25)(E) & (F) of the Act; 42 CFR 433.139 (b))
Identifying Third Parties

Third parties may be identified through:

- Information provided by the beneficiary at application, redetermination, or whenever changes occur;
- Data matches (public agencies and health insurers);
- Trauma code edits of Medicaid paid claims;
- Attorney reporting when representing a Medicaid beneficiary in a casualty/tort case; and
- State IV-D enforcement activity to establish medical child support (health insurance or cash support).
Identifying Third Parties at Intake

- States collect TPL information during initial determination and at redetermination of eligibility (changes only).
- States may use the streamlined model application or a CMS-approved alternative application.
  - The model application asks if the applicant has private insurance, and additional questions if the response is positive.
  - CMS-approved alternative applications may also ask for some policyholder information.
Identifying Third Parties at Intake (Continued)

- The Social Security Administration (SSA) collects information for states that grant Medicaid eligibility to SSI beneficiaries without requiring a separate application, per section 1634 of the Act.
- CMS maintains an interagency agreement with SSA to support this activity for “1634” states.
Identifying Third Parties through Data Exchanges

- Data Matches and Type of Information Obtained:
  - State Wage Information Collection Agencies (SWICA) - income verification,
  - Defense Enrollment Eligibility Reporting System (DEERS) - TRICARE coverage,
  - State Verification and Eligibility System (SVES) - Social Security numbers and benefits; Railroad Retirement benefits,
Identifying Third Parties through Data Exchanges (Continued)

- State Data Exchange (SDX) - SSI beneficiaries in “1634” states,
- Worker’s Compensation - possible casualty/tort claims,
- Motor Vehicle Accident Reports - possible casualty/tort claims, and
- Health plans - health insurance coverage.
Identifying Third Parties through Trauma Code Edits

States must:

- Identify diagnosis codes that are indicative of trauma, or injury, poisoning, and other consequences of external on claims submitted to Medicaid, and

- Follow up on codes to detect casualty-related claims for possible recovery.

States may exclude nonproductive codes from editing.

42 CFR 433.138(e)
Coordination of Benefits/Third Party Liability (COB/TPL)

Payment of Claims

2016
COB/TPL Staff

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Topics

Payment Methods
Establishing Thresholds
Procedural Restrictions
Provider Arrangements
Recouping from Providers
    ... more
Topics (continued)

Reporting
Pharmacy – Medicaid Subrogation
MMIS and Third Party Liability (TPL)
TPL Action Plans
Contingency Fee Contracts
Medicaid Payment Methods

There are two Medicaid payment methods:

- Cost Avoidance
- Pay and Chase
Cost Avoidance Payment Method

**Cost Avoidance**

- Providers must bill known third party resources (TPRs) before billing Medicaid, unless the Social Security Act (the Act) specifies that Medicaid will pay first and then seek reimbursement from the TPRs.

- Providers include any TPR collections amounts or payment denial reasons on their Medicaid claims.
Pay and Chase Payment Method

Pay and Chase

- Medicaid pays and then seeks reimbursement ("pays and chases"):  
  - When required by the Act;
  - When there is no known or available TPR at the time service is provided, but a TPR is identified later.
Cost Avoidance

- States ascertain the probable existence of TPRs; third party liability (TPL) for a specific service is determined when the provider receives a payment or denial response (claim adjudication) from the TPR.

- When the beneficiary has a TPR, states should reject any provider’s claim that the TPR hasn’t adjudicated and return it to the
provider to bill the TPR. Adjudicated claims denied solely for procedural reasons should also be returned.

- When Medicaid’s allowable payment is greater than what the TPR paid, states should make payment based on their approved state plan payment rate for the service. (42 CFR 433.139(b)(1))
Cost Avoidance – Permissible Pay without TPR Claim Adjudication

- The state may pay a claim for an insured Medicaid beneficiary when clear and convincing evidence confirms that:
  - the services provided are never covered by a liable third party, or
  - third party benefits are not available to pay at the time the claim is filed.

- 42 CFR 433.139(c); State Medicaid Manual (SMM) Section 3904.3
Allowable documentation includes:

- Confirmation by the state insurance commission that a service may not be covered for all or some beneficiaries in policies issued in the state, or
- Verification through a state Medicaid agency survey of major insurers in the state that a service is not covered.
State savings from cost avoidance accrue from:

- Keeping Medicaid funds in interest-bearing accounts until providers submit claims for insured beneficiaries that list TPR payments received or denied, and

- Reducing utilization of information systems and staff time to review, reject, return claims without TPR information to providers.

(SMM Part-03 Section 3904.1)
Pay and Chase

Medicaid pays the provider based on the state plan rate and later seeks recovery of payment from the liable third party.

(Section 1902(a)(25)(B) of the Act, 42 CFR 433.139(b)(2) and (3), and SMM Section 3904.4)
Pay and Chase (Continued)

If TPR becomes known after the claim has been paid, the state will seek recovery from the TPR, to the limit of liability within 60 days from the end of the month in which TPL is learned or benefits become available, whichever is later.

(42 CFR 433.139(d)(2), SMM Section 3904.3)
Mandated Pay and Chase

Pay and chase is mandated for situations involving:

- Prenatal care services;
- Preventive pediatric services;
- State Child Support Enforcement Agency actions to establish or enforce health insurance coverage from a non-custodial parent (sections 1902(a)(25)(E) and (F) of the Act); and
State payment for a service included in an insured child’s Individualized Education Program (IEP) or Individual Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA). (section 1903(c) of the Act)
Permissible Pay and Chase

Pay and chase is permitted in each of the following situations:

- Medicaid learns about TPL after having paid the claim.
- The state has a cost avoidance waiver.
Pay and Chase: Cost Avoidance Waivers

- Review and approval of waiver requests requires that the states demonstrate that pay and chase processing is more cost effective than cost avoidance processing.
- The authority to approve, disapprove, or rescind a cost avoidance waiver resides with the CMCS Director.
Inappropriate Pay and Chase

- Cost avoidance is required unless pay and chase is mandated or permitted.

- If a state pays a provider and then discovers a TPR, the state must seek reimbursement from the TPR, unless it’s not cost effective to do so (i.e., the amount of money the state expects to recover is less than the cost to recover).

(Section 1902(a)(25)(B), 42 CFR 433.139(f)(1), SMM Section 3904.3)
Payment Policy: Establishment of Cost Effectiveness Thresholds

- The state plan must specify threshold amounts or guidelines used for determining when it is cost effective to seek recovery.
- Claims may be accumulated to meet the threshold based on claims accrued within a specified period of time.
- Recovery should be sought when the threshold is reached.
Procedural Restrictions on Third Parties (except Medicare and TRICARE)

Per state laws to implement provisions of the Deficit Reduction Act (DRA) of 2005, when Medicaid files a claim, third parties must:

- Allow at least 3 years for states to submit claims,
- Allow 6 years from the date the Medicaid agency submits a claim to resolve procedural issues before a claim can be denied, and
Procedural Restrictions on Third Parties (except Medicare and TRICARE) (Continued)

- Not deny Medicaid claims for procedural reasons, i.e. filing limits, claim format, failure to present card at point of service, failure to obtain prior authorization, etc.
A preferred provider arrangement exists when a provider has an agreement with a third party to accept payment for less than the charged amount.

- The amount agreed upon by the provider and the third party is the maximum allowable provider reimbursement for the service.

(SMM section 3904.7)
Provider Arrangement - Example of Payment Liability

- Provider’s billed charge to insurance plan: $70
- Provider agreed with insurance plan to: $53
- Patient liability per the insurance plan: $15
- Insurance plan pays provider ($53 - $15): $38
- Medicaid state plan rate for the service: $45
- Medicaid pays the provider ($45 - $38): $7
- Medicaid’s payment plus the plan’s payment is full satisfaction for the cost of service. (Note: If the Medicaid rate for the service was $53, Medicaid would have paid the provider $15.)
- The patient is not liable for any payment to the provider.
Payment Policy
Recoupment from Providers

- Instead of pursuing reimbursement from the third party, states sometimes recoup money directly from providers, particularly when Medicare is a third party.

- Recoupment is appropriate when the state has a reasonable assurance that TPR benefits are available and the timely filing period for the provider to submit claims hasn’t expired.
Reporting Cost Avoidance Savings and TPL Collections to CMS

- States report savings and collections quarterly on the CMS 64 Summary and 64.9a reports.

- Cost avoidance & collections reported:
  - Health insurance
  - Casualty
  - Medicare
  - Probate
Pharmacy Subrogation Transaction

The Medicaid agency uses this HIPAA standard transaction to transmit a Medicaid-paid claim to a TPR for reimbursement of Medicaid’s expenditure on behalf of a beneficiary.

(46 CFR 162.1901 and 162.1902)
The MMIS TPL Subsystem is essential to COB/TPL.

The TPL Subsystem enables Medicaid to:

- Utilize private health, Medicare and other TPL resources, and
- Ensure that Medicaid is the payer of last resort.
The TPL subsystem must include:

- Insurance carrier data,
- Health plan coverage data,
- Cost–effectiveness threshold levels, and
- Post-payment recovery and collection of Medicaid paid amounts from TPRs, including casualty/tort and estate recovery claims.
The TPL subsystem uses MMIS edit/audit functions and claims processing functions to support cost avoidance and post-payment recovery and collection of Medicaid paid amounts for which a third party is liable, including casualty/tort and estate recovery claims.
Cost avoidance is implemented by using MMIS edits/audits that compare claim information to various data on the beneficiary subsystem, TPL subsystem, reference files and other MMIS files.

MMIS edits claims for beneficiaries with known third party coverage; claims require a TPR payment amount or substantive denial before Medicaid will pay.
TPL Action Plan

- Every state should have an up-to-date, CMS-approved TPL action plan.
- The action plan is required in statute (section 1902(a)(25)(A)(ii) of the Act) and regulation (42 CFR 433.138 (k)).
- The SMM provides additional guidance for states (section 3902.2).
TPL Action Plan (continued)

In tandem with the MMIS, these narrative plans describe the actions and methodologies the state will follow to:

- Identify TPRs,
- Avoid payment of claims with known TPRs,
- Recover reimbursement from TPRs, and
- Record information and actions relating to the state’s COB/TPL activities.
Contingency Fee Contracts

- States are allowed to enter into contingency fee contracts (CFCs) for COB/TPL activities.
  - States must submit their CFCs to the CMS Regional Office (RO) for approval.
- Contractors are reimbursed by retaining a percentage of recovered dollars.
- CFCs may not permit a lump sum payment to a contractor simply for identifying a beneficiary who has other health insurance. (SMM Section 2975)
Coordination of Benefits/Third Party Liability (COB/TPL)

Casualty/Tort

2016
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Topics

Casualty/Tort “Basics”
Definitions
State Responsibility to Seek Restitution
Cost-Effectiveness Thresholds
Cost-Effectiveness Claims Reduction
No Compromise
Adjusting Claims for Legal Fees and Costs
Topics (Continued)

Distribution of the State Collections
Reporting Tort Recoveries to CMS
Settlements and Awards: Limitations on Recovery
Dual Eligibles and Tort Claims
Mass Tort Litigation (Global Settlements)
False Claims Act
Casualty/Tort Basics

A Medicaid beneficiary may need medical items or services because of injury caused by the action, inaction, or negligence of a third party.

Examples: vehicular accidents, sports-related injuries, job-related injuries, injury caused by a defective product, medical malpractice, and neglect or abuse.
Casualty/Tort Basics (Continued)

- In these situations, the actions of another create a cause of action for the injured party, who may make a claim for damages for medical and other losses incurred because of the injury.

- Claims in these cases may be settled with or without court action.
Casualty/Tort Basics (Continued)

Medicaid programs that have paid for medical items or services have an interest in these cases, based on the Medicaid beneficiary’s assignment of his/her rights to third party payments to the Medicaid program as a condition of eligibility, in accordance with section 1912(a)(1)(A) of the Social Security Act (the Act).
This assignment gives the Medicaid program a right of subrogation, allowing the program to “stand in the shoes” of the Medicaid beneficiary, who has made a claim against a liable third party.

Medicaid may recover from settlements, but only from compensation designated for paying medical expenses.
Definitions

- **Subrogation** – assuming the legal rights of a person for whom expenses have been paid.
- **Tort** – a wrongful act (either intentionally or through negligence) resulting in injury.
- **Tortfeasor** – a person who commits a tort.
State Responsibility to Seek Restitution of Medicaid Payments

- States must seek full restitution of the amounts Medicaid expended on the beneficiary’s behalf related to the injury.
- States are limited in their recovery by the amount designated for paying medical expenses in a settlement.
- In tort situations, states are prohibited from imposing liens against a beneficiary’s personal property. (section 1917 of the Act)
State Responsibility: Setting Cost-Effectiveness Thresholds

- States may not pursue recovery unless it is cost-effective to do so. (42CFR433.139(f)(1))
- States set cost-effectiveness thresholds in the Medicaid state plan for initiating recovery action, based on state experience. (Medicaid State Plan, Section 4.22)
- Thresholds may be specific dollar amount of paid claims, a set time period to accrue claims, or both.
State Responsibility: Applying Cost-Effectiveness Thresholds

- States may determine it’s cost-effective to pursue a lesser amount to achieve recovery and avoid costs of litigation.

- States must apply cost-effectiveness criteria on a case-by-case basis, and may give consideration to potential beneficiary hardship.

- Claim reduction based on cost-effectiveness is not considered to be a compromise of the claim.
No Compromises

- Federal law does not permit a compromise or reduction of the federal share of the amount actually recovered by the state.

- After determining the amount to be recovered from the settlement, states may waive the state share of collections, but not the federal share.
Adjusting Claims for Legal Fees and Costs

- Option 1: Attorney’s fees, litigation and witness costs may be deducted from the settlement before reimbursing Medicaid.

- Option 2: States decide on a case-by-case basis to share in the costs, deducting a proportionate share of the costs from Medicaid’s share. Federal financial participation (FFP) for paid costs is available at the administrative rate.
Example: Deducting before Reimbursing Medicaid (Option 1)

Medicaid claim amount: $40,000

Medical settlement amount: $200,000

Attorney fees and costs: -$50,000

Amount to be distributed: $150,000

Medicaid’s Net Recovery: $40,000
Example: Sharing in Legal Fees and Costs (Option 2)

Medicaid claim amount: $ 40,000
Attorney’s costs and fees: $ 50,000
Medical settlement amount: $200,000
Medicaid’s share of settlement amount ($40,000 ÷ $200,000 = 20%): 20%
Medicaid pays 20% of legal costs ($50,000 x 20% = $10,000): $10,000
Medicaid’s Net Recovery ($40,000 - $10,000 = $30,000): $30,000
Distribution of the Amount Collected by the State

- The state retains the portion of the recovered amount equal to its share of costs of care (less any amount waived or reduced by the state to reach settlement).
- The federal government receives a portion of the recovered amount based on the FFP rate.
- The beneficiary receives the remainder including any portion reduced by the state.
States are required to report to CMS money recovered from tort settlements on the CMS-64 “Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program”.
Settlements and Awards: Limitations on 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.
- The settlement or award may allocate specific amounts for compensation of each type of loss.
- The U.S. Supreme Court’s decision in *Arkansas DHHS v Ahlborn*, May 2006, limits Medicaid recovery to the medical expense portion of the settlement only.
Arkansas DHHS v. Ahlborn
(U.S. Supreme Court – May 1, 2006)

- Prior to the *Ahlborn* decision, states sought recovery from the entire settlement.
- The U.S. Supreme Court ruled that assignment of rights was limited to the amount designated as compensation for medical expenses.
Arkansas DHHS v. Ahlborn (Continued)

- Attempts to recover amounts other than medicals violate the anti-lien statute (section 1917(a)(1) of the Act) because the remainder of the settlement funds becomes the Medicaid recipient’s personal property.

- The *Ahlborn* decision applies to settlement of claims open on or after May 1, 2006.
States are allowed, but not required, to use the *Ahlborn* formula (see explanation below, and following example) to determine the Medicaid share of the medical portion of the settlement:

- Determine the ratio between the settlement amount and the alleged damages.
- Apply the same ratio to the amount of medical expenses being sought by Medicaid.
The *Ahlborn* Formula (Continued)

Alleged damages: $3.04 Million
Claim settled for: $550,000 (approx. 1/6 of the value)

Medicaid’s claim: $215,645
Medicaid entitled to 1/6 of its claim amount: $35,581
State Options in Light of *Ahlborn*

State actions to mitigate the adverse affects of the *Ahlborn* decision:

- Involvement in the litigation process and influencing the amount allocated to medicals,
- Mandatory joinder (Medicaid joins the injured beneficiary’s suit), and
- Mandatory attorney notification to Medicaid.
State Options: Allocation of Medical Expenses

- Influencing the amounts to be attributed to medicals is key to maximizing recoveries.
- States may enact laws that provide for a specific priority to repayment of medical expenses among damages.
States may enact laws to require joinder to the injured party’s claim by the Medicaid program when Medicaid has paid for care related to the cause of action.

- Joinder means joining of two or more legal issues together, when the issues or parties overlap enough to make joining them more efficient and fair to all.
State Options: Attorney Notification

States may enact laws to create (or strengthen) the duty of attorneys to notify Medicaid when representing a Medicaid beneficiary, and to cooperate when settling claims.
Limitations on State Actions

Certain provisions in state law would violate the anti-lien provisions of section 1917 of the Act and cannot be applied to Medicaid beneficiaries’ casualty/tort claims.
Limitations on State Actions: Examples

- State law may not designate a set portion of the total settlement for Medicaid.
- State law may not automatically allow the Medicaid beneficiary to retain a portion of the settlement (fixed amount, set percentage, or variable amount).
Settlements Involving Dual Eligibles

- Medicare’s recovery rights, even when another payer is primary, take precedence over the right of any other entity. (42 CFR 411.24(g))
- Medicare has first claim on the settlement amount, before the beneficiary or Medicaid.
- Medicare may compromise its claim.
- Medicare generally will not compromise to the benefit of the Medicaid program.
Mass Tort Litigation/Global Settlements

- Class action product liability and consumer fraud lawsuits are filed against companies that manufacture drugs and medical devices and products.

- These suits may involve hundreds, or thousands, of plaintiffs (including Medicaid beneficiaries) crossing state lines.

- The suits are referred to as “mass tort litigation” and often result in global settlements.
Global Settlements

- Mass tort claims require a streamlined litigation process.
- Awards may be based on a matrix categorizing claims into subgroups, using various factors:
  - Diagnosis, severity of injury, health history, age, pre-existing conditions, causal link between the injury and drug, medical device or product.
Global Settlements (Continued)

- An independent firm (sometimes referred to as a Special Master) is often employed to administer the streamlined process and develop the settlement matrix.
Global Settlements (Continued)

- The administrative burden placed on states to determine actual medical costs attributed to the injury for multiple recipients can be prohibitive:
  - Pulling multiple claims going back many years, and
  - Litigation risk in proving Medicaid’s claims.

- It can be cost effective for states to agree to a settlement matrix.
State Flexibility in Global Settlements

- States may:
  - Work within an established litigation process;
  - Work with the Special Master to determine which settlement matrix category each affected Medicaid beneficiary fits into and, thus, determine the beneficiary’s allocated settlement amount; and,
State Flexibility in Global Settlements (Continued)

- Agree to be bound by a settlement which compensates the state for a reasonable estimate of medical expenses incurred by the state.
- State participation in such agreements does not violate the no-compromise policy.
False Claims Act (FCA)

- The Act provides penalties for anyone who knowingly submits or causes the submission of false or fraudulent claims to the United States government.

- A citizen who files an FCA suit is called a “relator”.

- A relator may receive 15 – 25% of recovered damages.
A relator may file an FCA suit “under seal”, so the suit won’t appear on the public record for a court-determined period.

A relator may initiate a suit on behalf of the U.S. government, which is allowed to join the suit. These are called “Qui Tam” suits.

The Department of Justice confers with CMS on joining any suit involving Medicaid.
Coordination of Benefits/Third Party Liability (COB/TPL)

Estate Recovery and Liens

2016
COB/TPL Staff

CMCS/DEHPG
Division of Health Homes, PACE, and COB/TPL
Director: Carrie Smith
COB/TPL Team:
- Technical Director: Nancy Dieter
- Health Insurance Specialists:
  Cathy Sturgill, Ginger Boscas, Sara Rhoades
Topics

Estate Recovery:
Statutory Authority and “Estate” Definition
Services Subject to Recovery
Medicare Savings Program Exceptions
When Recovery Is Prohibited
Waiving or Reducing Recovery
American Indian/Alaska Native Exceptions
Affordable Care Act (ACA) and Estate Recovery
Topics (Continued)

Medicaid Liens:
Definition of “Lien”
Statutory Authority
Types of Medicaid Liens
TEFRA Liens
ACA and Liens
Medicaid Estate Recovery

When a Medicaid beneficiary dies, states are required under federal law (sections 1902(a)(18) and 1917 of the Social Security Act (the Act)) to recover up to the total amount spent by Medicaid on that person’s behalf at age 55 and over, or when permanently institutionalized, unless statutory exemptions from recovery apply.
Statutory Authority for Estate Recovery

- Section 1902(a)(18) of the Act requires compliance with section 1917.
- Section 1917(b) of the Act applies to estate recoveries; it has been modified by the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), American Recovery and Reinvestment Act of 2009 (ARRA), and the Medicare Improvements for Patients and Providers Act of 2010 (MIPPA).
Legislative Changes: OBRA 93 and ARRA (2009)

- OBRA 93 made previously optional Medicaid estate recovery mandatory and changed the minimum age from 65 to 55.
- ARRA (2009) incorporated limitations on recovery from the estates of American Indians/Alaska Natives that were in section 3810.A.7 of the State Medicaid Manual into section 1917 of the Act by reference.
Legislative Changes: MIPPA

- MIPPA section 115 excluded from estate recovery any Medicaid payment for Medicare cost sharing amounts made for Medicare Savings Program (MSP) beneficiaries for services received on or after January 1, 2010.
Legislative Changes: MIPPA (Continued)

- MSP beneficiaries include Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Disabled Working Individuals (QDWI), and Qualified Individuals (QI).
“Estate” Defined for Medicaid Estate Recovery

- The minimum definition of estate is the state’s probate law definition (state law governing settlement of a decedent’s estate).
- Expanded definition of estate (state option): any other real and personal property, and other assets in which the individual had a legal title or interest at the time of death.
- The state establishes its definition in Attachment 4.17-A of the Medicaid state plan.
States must recover for nursing facility services, home and community based services, and related hospital services and prescription drugs.

States have the option to recover for any other service covered in the Medicaid state plan, except Medicare cost sharing for MSP beneficiaries.

The state records its election in section 4.17 of the Medicaid state plan.
Estate recovery is not permitted when there is a surviving spouse, or a child under age 21, or a blind or disabled child of any age.
When Estate Recovery Claims May Be Reduced or Waived

- States may adjust or waive the Medicaid claim if collection would cause an undue hardship on the deceased beneficiary’s survivors.

- Examples: the property subject to estate recovery is the sole income-producing asset of the survivors or a homestead of modest value, requiring estate recovery would result in an heir becoming eligible for Medicaid, etc.
When Estate Recovery Claims May Be Reduced or Waived (Continued)

- The state establishes specific hardship standards, and procedures for waiver or adjustment and notification to individuals of intent to recover.
- Notice must include the process, e.g. application for undue hardship waiver, hearings and appeals.
- The state records its hardship standards and procedures in section 4.17 of the Medicaid state plan.
Reducing or Waiving Claims for American Indians and Alaska Natives

- Various limitations on recovery from the estates of deceased American Indian/Alaska Native Medicaid beneficiaries are listed in the State Medicaid Manual, section 3810.A.7.

- Section 5006(c) of ARRA 2009 incorporated these limitations by reference in section 1917 of the Act.
Reducing or Waiving Claims for American Indians and Alaska Natives (AI/ANs) (Continued)

- Exclusions: tribal land or other property held in trust by the U.S. government for AI/ANs, income derived from that property, land on a reservation, income derived from rents or payment for usage rights such as timbering, fishing, etc., and items of unique spiritual or cultural value, and items that support a traditional lifestyle.
The Affordable Care Act (ACA) and Estate Recovery Rules

- ACA did not modify estate recovery requirements in section 1917 of the Act, as amended by OBRA 93, MIPPA 2008, and ARRA 2009; all requirements apply to the ACA Medicaid Expansion (MAGI) beneficiaries,

-BUT-

- States may elect to recover only the mandatory services for the MAGI group, even if they recover for mandatory and optional services for other beneficiaries.
The scope of recovered services for all groups must be specified in section 4.17 of the Medicaid state plan.
Medicaid Program Liens

A lien is a right to enforce a charge against an individual’s real property.

- Placement of a lien encumbers the title to property.
- A lien must be satisfied before the property subject to the lien may be sold and a clear title passed to the new owner.
- A Medicaid program may impose a lien for certain Medicaid benefits paid incorrectly or correctly during the lifetime of the beneficiary.
Statutory Authority for Medicaid Liens

- Section 1902(a)(18) of the Act requires compliance with §1917.

- Section 1917(a) of the Act applies to liens.
  - Section 1917(a) has been modified by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).
Types of Liens a State Medicaid Program May Impose

- Mandatory: per a court judgment, to repay the Medicaid program for benefits incorrectly paid

- Optional: when a beneficiary is determined to be permanently institutionalized, if the state imposes TEFRA liens (some restrictions apply)
Optional TEFRA Liens: Restrictions

- TEFRA liens apply to permanently institutionalized beneficiaries who have to apply their income to costs of care.
- The state Medicaid program determines the criteria for considering the beneficiary to be permanently institutionalized.
Exceptions to TEFRA Liens

- The state may not impose pre-death liens if any of the following individuals are lawfully living in the home (while the beneficiary is institutionalized):
  - Spouse,
  - Beneficiary’s child under age 21, or blind or disabled child of any age, or
  - Beneficiary’s sibling who has an equity interest in the home.
Removal of TEFRA Lien

- The state must remove (“dissolve”) the lien when the beneficiary is discharged from the medical facility and returns home.
ACA and Lien Imposition Rules

- ACA did not revise the lien imposition rules,
- BUT-
- Medicaid Expansion (MAGI) beneficiaries are not subject to TEFRA lien imposition.
- MAGI beneficiaries do not meet the statutory definition of beneficiaries to whom TEFRA liens apply (beneficiaries who have to spend for the costs of their medical care all income except a minimal amount reserved for personal needs).
Estate Recovery and Liens

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

Dual Eligible Beneficiaries

2016
COB/TPL Staff

CMCS/DEHPG
Division of Health Homes, PACE, and COB/TPL

Director: Carrie Smith

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Topics

- Defining Dual Eligibles
- Categories of Dual Eligibles
- Benefits for Different Categories of Dual Eligibles
- Coordination of Benefits with Medicare
Topics (continued)

- Balance Billing Protections

- Special Considerations: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for Certain Dual Eligibles
Who are Dual Eligibles?

Dual Eligibles are Medicare beneficiaries:

- who have limited income and resources, and
- are also eligible for some form of Medicaid.
Categories of Dual Eligibles

- Medicare Savings Programs (MSP)
  - Qualified Medicare Beneficiaries (QMB)
  - Specified Low-Income Medicare Beneficiaries (SLMB)
  - Qualifying Individuals (QI)
  - Qualified Disabled Working Individuals (QDWI)
Persons eligible for MSP as QMBs or SLMBs and also eligible for full Medicaid benefits under another eligibility category:

- QMB Plus (means “plus” Medicaid)
- SLMB Plus (means “plus” Medicaid)

Medicaid beneficiaries who also have Medicare, but who do not qualify for the MSP:

- Full Benefit Dual Eligibles (FBDE)
Eligibility Criteria

What determines which category a dual eligible is in?

Primarily, it depends on the individual’s or couple’s countable resources and income.
MSP Resource Limit (Effective 2016)

- QMB, SLMB, QI:
  - Individual - $7,280
  - Couple - $10,930

- QDWI:
  - Individual - $4,000
  - Couple - $6,000
Eligibility Criteria (Continued)

MSP Income Levels:

- QMB – Up to 100% of the Federal Poverty Level (FPL) + $20
- SLMB – 100-120% FPL + $20
- QI – 120–135% FPL + $20
- QDWI – up to 200% FPL + $20 - (individuals also must be employed and not otherwise eligible)
MSP Financial Eligibility

- Eligibility limits may be impacted by a state’s choice to use disregards in section 1902(r)(2) of the Social Security Act (the Act).

- Section 1902(r)(2) disregards vary by state.
Eligibility Criteria (QMB Plus, SLMB Plus, and FBDE)

- Anyone who also qualifies for state plan services (e.g., QMB Plus, SLMB Plus) must, of course, meet the Medicaid limits as well as MSP limits.

- Medicare beneficiaries who qualify for Medicaid but not MSP (e.g., FBDE) must meet Medicaid limits.

- Medicaid resource and income limits and methodologies vary from state to state.
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Benefits for Dual Eligibles (Continued)

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Medicare Cost-Sharing for QMBs

- QMB only beneficiaries are eligible for Medicaid payment of all Medicare premiums, deductibles, coinsurance and co-payments only, regardless of whether or not the services are included in the State Plan.
QMB plus beneficiaries are eligible for Medicaid payment of all Medicare premiums, deductibles, coinsurance and co-payments, regardless of whether or not the services are included in the State Plan; these beneficiaries are also eligible to receive all Medicaid state plan services.
Medicare Cost-Sharing for SLMBs

- SLMB only beneficiaries receive Medicaid payment of Medicare Part B premiums only.
- SLMB plus beneficiaries receive Medicaid payment of Medicare Part B premiums; these beneficiaries are also eligible to receive all Medicaid state plan services.
- States may pay Medicare cost-sharing for all Medicare services or Medicaid state plan services only, as the state chooses.
Medicare Cost-Sharing for FBDEs

- FBDE beneficiaries receive Medicaid payment of Medicare Part B premiums and are also eligible to receive all Medicaid state plan services.

- States may pay Medicare cost-sharing for all Medicare services or Medicaid state plan services only, as the state chooses.
Coordination of Benefits with Medicare

- Medicaid is the payer of last resort, i.e., Medicare is primary to Medicaid.

- States make payment of Medicare cost sharing according to the payment methodology specified in Supplement 1 to Attachment 4.19-B of the state plan.
Coordination of Benefits with Medicare (Continued)

States have the option to:

- pay full Medicare deductibles, co-insurance and co-payment amounts (recorded in the state plan as Medicare Rate or MR), or,

- limit payments to amounts based on the state plan payment rates (recorded in the state plan as State Payment or SP): or,
Coordination of Benefits with Medicare (Continued)

- identify a negotiated rate that:
  - sets the payment level between the Medicaid and Medicare rates; or,
  - establishes a payment level acceptable to CMS for Medicare services that aren’t covered in the state plan.
- These rates are recorded in the state plan as negotiated rate or NR.
Coordination of Benefits with Medicare (Continued)

- State may choose different payment methodologies based on:
  - category of dual eligible;
  - Medicare Part A or Part B services;
  - specific service (e.g., ambulance, nursing home, etc.); and/or,
  - type of provider approved to render a specific type of service.
The state’s selected payment methodologies can be found within the state plan at Supplement 1 to Attachment 4.19-B, pages 1-3+.

Limiting payments to the Medicaid rate may result in no actual payment being made for co-insurance and co-payments if the Medicare payment received exceeds the Medicaid rate.

Both Title XVIII and Title XIX prohibit providers from balance billing dual eligibles.
Coordination of Benefits with Medicare Advantage (Part C)

- Some beneficiaries receive their Part A and Part B coverage through private health plans, referred to as Medicare Advantage plans or Medicare Part C plans. Medicare Advantage plans may also include prescription drug coverage offered under Part D and other supplemental benefits.

- Mandatory supplemental benefits are included for all enrollees in the Medicare Advantage plan.
Optional supplemental benefits are available if the beneficiary elects to receive them.

CMS sets rules for and approves Medicare Advantage plans, plan benefits, and cost sharing for enrollees.
Some states make per capita payments for cost sharing for Part C plan beneficiaries. Capitated payments must be based on a methodology identified in the state plan and incorporate the same general payment limitations.
Medicare Advantage plans, however, are not required to accept these capitation payments. In this case, state Medicaid agencies will still cover Part C cost sharing for QMBs and FBDEs, but the providers must submit claims directly to the state agency.
## Benefits for Medicare Advantage (Part C)

### Medicaid Payment for Costs Associated with Medicare Part C

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Benefits for Medicare Advantage (Part C, Continued)

Medicaid Payment for Costs Associated with Medicare Part C

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Benefits for Medicare Advantage (Part C, Continued)

* State Medicaid agencies are liable for a portion of the cost sharing for beneficiaries in the SLMB Plus category 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 pays more than the Medicare payment amount. In these circumstances, the agency must reimburse the provider up to the amount for the service specified in the state plan.
Benefits for Medicare Advantage
(Part C, Continued)

- **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 state Medicaid agency limits Medicaid payment as specified in Supplement 1 to Attachment 4.19-B of the state plan. These payment limitations may result in a Medicaid payment of zero.
Benefits for Medicare Advantage (Part C, Continued)

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. Medicaid agencies may elect this option in the state plan.
Benefits for Medicare Advantage (Part C, Continued)

Conditional: For a non-QMB eligible, there is no Medicaid liability for cost sharing in a Medicare Advantage plan, however, state Medicaid agencies are liable for payment for Medicaid-covered services rendered by Medicaid providers to Medicaid eligible individuals in excess of any third party (including Medicare Part C) liability.
When all of 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.
- The amount specified in the state plan is greater than the Medicare payment amount.
Balance Billing Protections

- Providers are strictly prohibited under section 1902(n)(3) of the Act from seeking to collect any additional amount from a QMB for Medicare deductibles or coinsurance (other than nominal Medicaid copayments), even if the Medicaid program’s payment is less than the total amount of the Medicare deductibles and coinsurance.
DMEPOS for Certain Dual Eligibles

- All dual eligibles enrolled in Part A and Part B who live in an area covered by Medicare’s competitive bidding program must receive DMEPOS services from a contracted provider, unless an exception applies.

- This requirement applies to dual eligibles enrolled in a Medicaid managed care organization (MCO), if the state Medicaid program pays the MCO capitation rate that includes MCO payment of Medicare cost-sharing amounts.