3900. THIRD PARTY LIABILITY (TPL)

3900.1. General Purpose.--The purpose of establishing and maintaining effective TPL programs is to reduce Medicaid expenditures. Third parties are entities or individuals who are legally responsible for paying the medical claims of Medicaid recipients. Federal law and regulations require States to assure that Medicaid recipients utilize all other resources available to them to pay for all or part of their medical care needs before turning to Medicaid. This may involve health insurance, casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more recipients. Medicaid pays only after the third party has met its legal obligation to pay; i.e., Medicaid is payer of last resort.

HCFA and a State workgroup developed and published A Guide to Successful State Agency Practices which contains various State TPL practices that were selected based on the cost effectiveness of implementation and ongoing operation as well as long range TPL savings and recoveries to the State. The guide has been distributed to all State Medicaid agencies to be used as a management tool to assist you in upgrading and improving TPL programs. Refer to the guide in considering changes to your current TPL programs.

3900.2 Statutory Basis.--The following sections of the Social Security Act (the Act) set forth the requirements for TPL:

1902(a)(25) Requires that States or local agencies take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid applicant or recipient. Provides for the collection of health insurance information.

1902(a)(45) Provides for mandatory assignment of rights to payments for medical support and other medical care owed to recipients.

1903(d)(2) Allows 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 §1912.

1912(a)(1) Requires as a condition of eligibility:

- Assignment to the State of rights to medical support and to payment for medical care from any third party;
- Cooperation, in the absence of "good cause", in establishing paternity and obtaining medical support and payments; and
- Cooperation, in the absence of "good cause", in providing information to assist the State in pursuing any third party liable for payment.

1912(a)(2) Requires that State plans 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 law enforcement officials.

3901. DEFINITIONS

Estate - Property (real or personal) in which one has a right or interest.

Decedent - A deceased individual whose estate is being probated.

Testator - A person who has died leaving a valid will.

Intestate - Not having made a will.

Administrator (Administratrix) - A representative appointed by the probate court to administer an estate, pay bills, and disburse assets of a decedent.

Executor (Executrix) - Person nominated by a decedent in his will to carry out its provisions.

Probate - The act or process of proving the authenticity or validity of a will; the settlement of a decedent's estate.

Subrogation - Right of the State to stand in place of the client in the collection of third party resources.

Third party - Any individual, entity, or program that is, or may be, liable to pay all or part of the medical cost of any medical assistance furnished to a recipient under the approved State plan. Third parties include, but are not limited to:

- Private health insurance;
- Employment-related health insurance;
- Medical support from absent parents;
- Automobile insurance (including no-fault insurance);
- Court judgments or settlements from a liability insurer;
- State workers' compensation;
- First party probate-estate recoveries; and
- Other Federal programs (unless excluded by statute; i.e., Indian Health, Community Health, and Migrant Health programs).

Private insurer:

- Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated and indemnity contracts);

- Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for the diagnosis and treatment of an injury, disease, or disability; or

o Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments for services, including self-insured and self-funded plans.

Indemnity Policy.--Insurance which provides payment directly to the policyholder under certain conditions. Indemnity policies are a potential third party resource which are subject to the assignment of rights provisions if the benefits payable are designated for medical care or can be used for this purpose. There are many variations in this type of policy. Each policy must be examined to determine the type of benefit it provides and the purposes for which it can be used. If not a third party resource, the proceeds from this type of policy are usually considered income.

Cost Avoidance.--A method of avoiding payment of Medicaid claims when other insurance resources are available to the Medicaid recipient. Whenever the Medicaid agency is billed first, claims are denied and returned to the provider who is required to bill and collect from liable third parties. Cost avoidance also includes payment avoided when the provider bills the third party first.

Pay and Chase.--A method used where Medicaid pays the recipient§s medical bills and then attempts to recover from liable third parties.

Title IV-D Agency.--The organizational unit in the State responsible for administering or supervising the administration of a State plan for child support enforcement under title IV-D of the Act.

Medical Support - Payment of the costs of medical care ordered by a court or administrative process established under State law.

3902. GENERAL TPL REQUIREMENTS

Take reasonable measures to determine the legal liability of third parties to pay for services furnished under the Medicaid State plan (herein referred to as the State plan). At a minimum:

o Collect health insurance information during the initial eligibility interview process and the redetermination process. (See §3903.1.)

o Conduct diagnosis and trauma code edits to identify specific codes which could denote trauma related injury. (See §3903.2.)

o Conduct data exchanges with: (See §3903.3.)

- State wage information collection agencies,
- SSA wage and earnings files,
- State title IV-A agencies,
- State motor vehicle accident report files, and
- State workers' compensation or Industrial Accident Commission files.

Follow up on the information derived from these activities for the purpose of identifying third parties resources. Incorporate this third party information into the eligibility case file, the third party data base, and third party recovery unit. (See §3903.4.) If a third party resource is identified for an individual, use the information to seek recovery if you have paid claims for which a third party is liable and cost avoid future claims.

Use the cost avoidance method where the probable existence of TPL is established at the time a claim is filed unless you have an approved waiver as specified in §3904.2, or specific conditions exist as follows:

o The third party is derived from a parent whose obligation to pay medical support is being enforced by the State title IV-D agency and the provider has not received payment from the third party within 30 days after the date of services. (See §3904.4.A.); or

o Claims are for prenatal care for pregnant women, or preventive pediatric services (including early and periodic screening, diagnosis and treatment services (EPSDT)) that are covered under the State plan. (See §3904.4.B.) Seek recovery from the third party whenever you have paid a claim or claims for which a third party is liable. (See §3904.3.)

Determine and utilize cost effective thresholds on recovery actions. (See §3904.5.)

As a condition of eligibility, require that each applicant and recipient (see §3905):

o Assign his/her rights (and the rights of any other eligible individuals on whose behalf he/she has legal authority under State law to assign such rights) to medical support and to payment for medical care from any third party;

o Except for poverty level pregnant women (see §3311 ff), cooperate, in the absence of good cause, in establishing paternity and obtaining medical support and payments; and

o Cooperate, in the absence of good cause, in providing information to assist the State in pursuing any liable third party.

State title IV-D agencies are required to petition the court or administrative authority to include medical support in court orders. The IV-D agencies are also required to obtain basic medical support information and provide this information to you. (See §3905.6.)

The State plan must provide for entering into cooperative agreements for the enforcement of rights and collection of third party benefits. The agreement(s) may be with the State title IV-D agency, any appropriate agency of any State, and appropriate courts and law enforcement officials. (See §3906.)

Submit a plan (herein referred to as the action plan) to the RO for pursuing claims against third parties, and integrate this action plan into the State's Medicaid Management Information System (MMIS). (See §3902.2.)

3902.1. State Plan Requirements--A State plan must:

- Provide that all the requirements of 42 CFR 433.138 and 433.139 are met for determining the legal liability of third parties to pay for services under the State plan and for payments of claims involving third parties. (See §§3903 and 3904.)

- Provide that the requirements of 42 CFR 433.145 through 433.148 are met for assignment of rights to benefits and cooperation with the agency in obtaining medical support or payments. (See §3905.)

- Provide that the requirements of 42 CFR 433.151 through 433.154 are met for cooperative agreements and incentive payments for third party collection. (See §3906.)

- Describe the methods the agency uses to follow up on health insurance information provided by SSA and State agencies other than the Medicaid agency. (See §3903.1.)

- Specify the frequency with which diagnosis and trauma code edits and data exchanges (i.e., SWICA, SSA wage and earnings files, State title IV-A agency, State worker's compensation or Industrial Accident Commission files, and State motor vehicle report files) are conducted (Attachment 4.22-A). (See §§3903.2 and 3903.3.)

- Describe the methods the agency uses to follow up on paid claims identified through conducting diagnosis and trauma code edits (Attachment 4.22-A). (See §3903.2.)

- Describe the methods the agency uses to follow up on data exchanges (Attachment 4.22-A). (See 3903.3.)

- Specify the timeframes for incorporation into the third party data base and third party recovery unit of all information that identifies legally liable third party resources (Attachment 4.22-A).

- Specify whether or not providers are required to bill the third party in situations where the third party liability is derived from a parent whose obligation to pay support is being enforced by the State title IV-D agency (Attachment 4.22-A). (See §3904.4.A.)

- Specify the method used in determining the provider's compliance with the billing requirement in situations involving medical support enforcement by the State title IV-D agency (Attachment 4.22-B). Providers are required to wait 30 days from the date of service to bill the State if they have billed the third party. (See §3904.4.A.)

- Specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party; or describe the process by which the agency determines that seeking reimbursement would not be cost effective. It must also specify the dollar amount or time period the State uses to accumulate billings with respect to a particular liable third party (Attachment 4.22-B). (See §3904.5.)

3902.2 Third Party Liability (TPL) Action Plan-If you have an MMIS, submit to the RO an action plan for pursuing claims against third parties. Automate the activities involved in pursuing TPL to the fullest extent possible. The action plan is to describe all TPL activities and is separate and distinct from the State plan. However, the action plan may incorporate, by reference, sections of the State plan that adequately describe particular TPL activities in accordance with the action plan guidelines. This is applicable to TPL activities which are contracted out by the State agency to a fiscal agent, as well as to activities involving contingency fee contractors.

The action plan is to be integrated with the MMIS and those portions which directly relate to the MMIS will be monitored as a part of the review of the system. Only the factors included in the system performance review will be subject to reductions in Federal financial participation (FFP) for failure to meet the conditions for reapproval as set forth at 42 CFR 433.119.

Submit to the RO your action plan by June 20, 1990. Submit subsequent changes to the action plan to the RO on an ongoing basis no later than 90 days from the date of implementation. The RO will approve or disapprove your action plan. The submittal of an approvable, current action plan is a State plan requirement.

The action plan must describe the actions and methodologies taken in the following areas:

- o Identifying third parties;
- o Determining the liability of third parties;
- o Avoiding payment of third party claims;
- o Recovering reimbursement from third parties after Medicaid payment; and
- o Recording and tracking such information and actions.

Use the following guidelines in developing your action plan:

I. Identification

A. Collection of Health Insurance Information (other than by the Social Security Administration (SSA)). (See 42 CFR 433.138(b)(1).)

1. What type of health insurance information is gathered from applicants/recipients (e.g., name of insurer, policy number, name of insured, services covered)?

2. Are names, SSNs, and possible third party resources of absent and custodial parents collected from applicants/recipients?

3. Who collects this information (e.g., State agency, county office, contractor)?

4. When and how is the information verified?

5. How are the data transmitted to the Medicaid agency? What are the timeframes for transmitting the data?

6. Where is the verified information maintained (e.g., eligibility case file, claims processing subsystem, third party data base, third party recovery unit)?

7. What actual information is maintained?

8. How does the TPL file data interface with the claims processing subsystem or other subsystems?

9. What are the timeframes for incorporating the information into the file or files mentioned above?

B. Health Insurance Information Collected by SSA (applies to States having a §1634 agreement) (See 42 CFR 433.l38(b)(2).)

1. Who receives the information from the Form SSA-8019?

2. How often is the information received?

3. When and how is the information verified?

4. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)

5. What actual information is maintained?

6. How does the TPL file data interface with the claims processing subsystem or other subsystems?

7. What are the timeframes for incorporating the information into the file or files mentioned above?

C. Data from Office of Child Support Enforcement Program (See 45 CFR 306.50.)

1. What medical support data elements are being received from the IV-D agency?

2. How often is the information received?

3. When and how is the information verified?

4. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)

5. What actual information is maintained?

6. How does the TPL file data interface with the claims processing subsystem or other subsystems?

7. What are the timeframes for incorporating the information into the file or files mentioned above?

8. Does the IV-D agency have access to your TPL data base?

9. Does the IV-D agency verify the current TPL status and that the data are correct?

II. Data Exchanges

A. State Wage and Income Collection Agencies (SWICAs) and SSA Wage and Earnings (Beneficiary Earnings Exchange Record (BEER)) Files (See 42 CFR 433.138(d)(1).)

1. Are you conducting data matches with State wage information collection agencies and SSA wage and earnings files?

2. Do you perform this match or does a contractor? If a contractor does it, who is the contractor?

3. Are the names and SSNs of absent parents being matched with SWICA and SSA files?

4. What is the process for conducting the data exchanges? (Include frequency of exchange.)

5. How do you follow up on and verify the information to determine if employer group health benefits are available directly to the Medicaid recipients or through an absent or custodial parent?

6. What are the timeframes for followup?

7. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)

8. What actual information is maintained?

9. How does the TPL file data interface with the claims processing subsystem or other subsystems?

10. What are the timeframes for incorporating the information into the file or files mentioned above?

11. Do you receive information from the IV-A agency that identifies Medicaid recipients who are employed and their employer(s)? If not, how do you obtain information for this population?

12. If SWICA and SSA wage and earnings data are not being utilized, does the agency have an alternative source of information? (Describe alternative method based on the above questions.) (See 42 CFR 433.138(d)(2).)

B. Workers' Compensation (See 42 CFR 433.138(d)(4)(i).)

1. Are you conducting data matches with the State's workers' compensation agency?

2. Do you perform this match or does a contractor? If a contractor does it, who is the contractor?

3. What is the process for conducting the data exchange? (Include frequency of exchange.)

4. Are the names and SSNs of absent parents being matched?

5. How do you follow up on and verify the information to determine if a Medicaid recipient has an employment related injury or illness?

6. How do you follow up on and verify the information to determine if employer group health benefits are available directly to a Medicaid recipient or through an absent or custodial parent?

7. What are the timeframes for followup?

8. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)

9. What actual information is maintained?

10. How does the TPL file data interface with the claims processing subsystem or other subsystems?

11. What are the timeframes for incorporating the information into the file or files mentioned above?

12. If you are not conducting data exchanges with workers' compensation, was a reasonable attempt made to do so? If yes, did you submit documentation with Attachment 4.22B of the State plan?

C. State Motor Vehicle Accident Report Files (See 42 CFR 433.138(d)(4)(ii).)

1. Are you conducting data matches with State motor vehicle accident report files?

2. Do you perform this match or does a contractor? If a contractor does it, who is the contractor?

3. Describe the process for conducting the data exchange. (Include frequency of exchange.)

4. How do you follow up on and verify the information to identify those Medicaid recipients injured in motor vehicle accidents (pedestrians, drivers, or passengers)?

5. How do you follow up on and verify third party resources that would be available through an automobile or liability insurance policy?

6. What are the timeframes for followup?

7. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)

8. What actual information is maintained?

9. How does the TPL file data interface with the claims processing subsystem or other subsystems?

10. What are the timeframes for incorporating the information into the file or files mentioned above?

11. If you are not conducting data exchanges with State motor vehicle accident report files, was a reasonable attempt made to do so? If yes, did you submit documentation with Attachment 4.22B of the State plan?

D. Other Data Exchanges

1. What other data exchanges do you conduct (e.g., private insurers, Defense Enrollment Eligibility Reporting System (DEERS), credit bureaus, fraternal organizations, unions.)?

For each of these data exchanges, answer the following questions:

2. Do you perform the match or does a contractor? If a contractor does it, who is the contractor?

3. Are the names and SSNs of absent and custodial parents being matched?

4. What is the process for conducting the data exchanges? (Include frequency of exchange.)

5. How do you follow up and verify the information?

6. What are the timeframes for followup?

7. Where is the verified information maintained?

8. What actual information is maintained?

9. How does the TPL file data interface with the claims processing subsystem or other subsystems?

10. What are the timeframes for incorporating the information into the file or files mentioned?

III. Diagnosis and Trauma Code Edits (See 42 CFR 433.138(e).)

1. Are you conducting diagnosis and trauma code edits for codes 800 through 999, with the exception of code 994.6? If not, list codes which are not being edited.

2. Do you conduct the diagnosis and trauma code edits or does a contractor? If a contractor does it, who is the contractor?

3. What is the process? (Include frequency of conducting edits.)

4. How do you follow up on and verify the information to identify possible trauma related injuries?

5. How do you follow up on and verify that third party resources may be available through a liability insurance policy?

6. What are the timeframes for followup?

7. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)

8. What actual information is maintained?

9. How does the TPL file data interface with the claims processing subsystem or other subsystems?

10. What are the timeframes for incorporating the information into the file or files mentioned above?

IV. Claims Payment

A. Cost Avoidance (See 42 CFR 433.139(b)(1).)

l. Which claim types, recipient populations, etc. are you cost avoiding?

2. What information is available through the recipient§s Medicaid identification medium, if any, indicating third party resources?

3. What is your process for cost avoiding claims? (Include use of contractor.)

4. How are electronic billers providing evidence of third party pursuit?

5. How do you control and verify the partial payment of claims (hard copy and electronic) after a third party has made payment?

6. What method do you use for tracking cost avoided dollars (as reported on the 64.9a, Medicaid Expenditures Report)?

   a. How do you account for initial claims, and reconcile the amount when the claims are resubmitted?

   b. Do you have a method for measuring cost avoided dollars for claims that are never received by the State? (If yes, describe method.)

   c. Do you account for claims denied for cost avoidance purposes only up to the Medicaid payment limit?

   d. Do you include Medicare or count it separately?

   e. Do you include recipient copayments?

   f. What do you include under "other cost avoidance"?

B. Pay and Chase and Recovery (See 42 CFR 433.139(b)(2)and(3).)

1. Which claim types are you paying and chasing? For which do you have a waiver? Explain those for which you do not have a waiver.

2. Are you currently paying and chasing claims in accordance with 42 CFR 433.139(b)(3)(i) and (ii)? (This section applies to claims for services for prenatal care for pregnant women, preventive pediatric services or covered services furnished in cases where the third party resource is derived from the absent parent whose obligation to pay third party medical support is enforced by the State title IV-D agency.)

3. Do you currently have recovery threshold amounts? If so, what are they and how were they determined? For threshold amounts greater than $100 for health insurance and greater than $250 for casualty claims, provide documentation including calculations showing that the threshold amounts are cost-effective.

4. Does the threshold include accumulated billing. If so, over what period of time?

5. How does the system identify when threshold levels are reached?

6. What is your process for seeking recovery? (Include use of contractor.)

   a. What codes, if any, are used for recovery purposes (e.g., HCPCS, diagnosis codes, other procedure codes)?

   b. How does the system identify individual claims for recovery?

c. In what order and from whom do you seek recovery?

d. How do you follow up to assure that collection was made? What are specific accounting and reporting procedures for recoveries?

e. If collection was not made, how does the system trigger followup?

f. How do you track actual dollars recovered?

g. How are TPL recoveries reconciled with the claims history? Specify the audit and control procedures followed.

h. What are the specific procedures for recovery in casualty cases involving settlement awards?

i. Do you have any formal billing arrangements/agreements with private insurers? If so, describe. (Include the information shared/required, timeframes, and how outstanding claim amounts are reconciled.)

V. Other

1. Do you pay premiums for health insurance policies if it is determined to be cost-effective? If so, provide methodology for determining cost-effectiveness?

2. What other TPL practices, not covered in these sections, do you pursue? For example, do you pursue estate recoveries? Describe how you approach any of these "other" practices.

3. Do you use a contractor for any other TPL activities not covered here? If so, identify the contractor and describe the specific types of activities performed.

3902.3 System Capabilities--Automate the activities involved in pursuing TPL to the fullest extent possible. All systems (MMIS or otherwise) should have certain features in order for States to comply with Federal regulations and run an effective TPL program. The more specific the information fed into the system the better the TPL program will function. Following are TPL system capability requirements. The first column lists requirements which are effective June 20, 1990. The second column under A. and B. includes requirements that are effective at the time of the next scheduled reprocurement or replacement of your MMIS. If you do not have a reprocurement or replacement scheduled, the requirements are effective no later than September 30, 1992.

A. TPL MMIS System Requirements.--

Effective June 20, 1990	Effective September 30, 1992, or at Time of Next Scheduled Reprocurement or Replacement of MMIS
Store and retrieve TPL information including name and address of insurance policy number and group number (if applicable).	Store and retrieve TPL information on services covered, policy period, company, and multiple resources under one receipient.

Edit claims based on the existence of any form of Matrix by which claims are screened to form of insurance which may cover the particular claim determine if claim is for an individual particular claim in question and cost avoid the claim with TPL, if the service is covered by the claim whenever it is appropriate.(If the system does policy, and if the date of service is system does not not discriminate by type of within the coverage period.service, every claim flagged by the edit must be subject to manual review that matches the billed procedure with known insurance coverage.)

Override TPL cost avoidance edit(s) for claims that were billed to and denied by the TPL resource.

Account for TPL payment to the provider in determining the Medicaid payment.

Identify claims with trauma diagnosis codes.

Screen any verified TPL resource against a paid claims history going back at least one year to identify recoverable funds. (A shorter period of time may be considered if you can show it is not cost-effective to go back one full year.)

Accumulate claims up to a specified threshold amount.

Track and report cost avoidance dollars.

Associate recoveries back to individual claims (or functional equivalent). (It is important that you know which claims have been recovered, not only for internal accounting purposes, but to know which claims to pursue under estate recovery programs after the recipient's death. This function may be performed outside of the MMIS.)

B. TPL Automated Requirements (Non-MMIS).--

Effective June 20, 1990	Effective September 30, 1992, or at Time of Next Scheduled Reprocurement or Replacement of MMIS
Medicaid identification medium which identifies the existence of TPL.	Medium must include all relevant TPL data (i.e., insurer, type of coverage, start date, etc.) or a direct data link which

gives providers access to the State's payment system to ascertain the availability of third party resources and billing information.

Verify collection efforts made and "tickle" for followup.

C. TPL Recommended System Capabilities.--

- o Store and retrieve information on deductibles and copayments, if feasible.
- o Track deductibles and deny claims when deductibles have been met, if feasible.
- o Associate family members together even if they are separate cases in the State system.
- o Associate resubmitted claims with the original denied claim.
- o Automate recovery activities - Electronic submission of claims to insurers.
- o Automate data matches.

3903. IDENTIFICATION OF RESOURCES (42 CFR 433.138)

TPL depends to a large extent on the accurate and thorough identification of resources available to recipients. Nothing can be cost avoided or collected if the resource is not known.

3903.1 Intake Process.--All State agencies that determine eligibility for Medicaid must, during the initial application and each redetermination process, obtain from the applicant or recipient health insurance information useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified in §433.139(b) through (f). Many States have a 1634 agreement with SSA in which SSA determines Medicaid eligibility for individuals who apply for Supplemental Security Income (SSI) benefits. The SSA field offices collect health insurance data from the SSI applicants and recipients during the initial application and redetermination processes and transmit the information to the State Medicaid agencies.

Health insurance information may include, but need not be limited to, the name of the policyholder, his/her SSN, relationship to the applicant or recipient, name and address of the insurance company, and the policy number or group number, if applicable.

Sometimes applicants or recipients are not aware of potential health insurance coverage that may be available to them. In some cases it is not sufficient to simply ask during the initial application or redetermination process if health insurance is available. There are

other ways of detecting the existence of a third party during an interview. Be aware of what to look for. These indicators may also represent potential third party resources:

A. Age.--Applicants who are 65 or older are usually eligible for Medicare. Frequently, Medicare beneficiaries have insurance in the form of a Medigap policy which covers Medicare coinsurance and deductible amounts. Students may have insurance available through the school they attend. Minor children may be covered through an absent parent. (See subsection C.4.)

B. Death.--Question applicants on behalf of deceased persons about "last illness" coverage through any life insurance policies.

C. Income.--Certain income sources are indicators of possible third party health coverage.

1. Railroad Retirement Benefits and Social Security Retirement/Disability Benefits.--Indicate eligibility for Medicare benefits.

2. Longshore and Harbor Workers' Compensation (LHWC) and Workers' Compensation (WC).--Employees who suffer injury on the job may file for benefits to compensate for medical expenses as well as lost income. Payment for medical expenses may be made either as medical bills are incurred or as a lump sum award.

3. Black Lung (BL) Benefits.--Payments under the Coal Mine Workers' Compensation Program, administered by the Department of Labor (DOL), are similar to those described in subsection C.2, except that benefits are only awarded on a diagnosis of pneumoconiosis. The beneficiary may be reimbursed only if services are rendered by specific providers authorized by the DOL. BL payments are made monthly and medical expenses are paid as incurred.

4. IV-D Payment.--Financial support payments from an absent parent strongly indicate potential medical support as well. An absent parent may be required by court order to provide medical insurance in addition to support payments; he/she may be responsible for a portion of medical bills, or, if employed, may be required to include dependent children in the medical insurance made available by the employer. Federal regulations require the IV-D agency to develop medical support in addition to monthly child support payments for certain cases, and to provide this information to the Medicaid agency.

5. Earned Income.--Usually indicates medical and health insurance made available by an employer.

D. Work History.--May indicate eligibility for cash and medical benefits through previous employers. Retired individuals may be covered under a retiree's health insurance plan. Individuals belonging to a labor union may have coverage through the union. Previous military service suggests the potential for Department of Veterans Affairs or Department of Defense (DOD) provided health care. (See §3903.5 for more details concerning DOD.)

E. Monthly Expense.--Information may show that the recipient pays premiums for private health insurance or HMO enrollment.

F. Disability Information.--May indicate eligibility for other medical benefits. If disability resulted from an accident, casualty insurance may be available. Medicare is available to disabled persons who have received social security monthly disability benefits for two years and to certain persons suffering with end-stage renal disease who are receiving renal dialysis treatments or who have had a kidney transplant.

Follow up on the information gathered during the intake process to identify legally liable third party resources and incorporate such information into the eligibility case file, the third party data base and third party recovery unit as specified in §3903.4 within 60 days.

The 60 days begin on the date processing of the application is initiated (the date the agency learns of the potential third party resource) or the date the eligibility determination is made, whichever is later. For SSI recipients only, the 60 days begin upon receipt of the SSA-8019. In some cases followup may not be required since the applicant or recipient may supply complete identifying information during the eligibility determination or redetermination process. Use this information to seek recovery if you have paid claims for which a third party is liable. Create an edit in the claims processing system and cost avoid future claims in accordance with §3904.1.

3903.2 Claims Processing Edits.--Identify paid claims that contain specific diagnosis or trauma codes and follow up on information for purposes of identifying potentially liable third parties. Identify the paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 (International Classification of Disease, 9th Revision, Clinical Modification, Volume 1) with the exception of code 994.6, Motion Sickness, for the purpose of determining the legal liability of third parties.

Based on experience, you may find that the identification and followup of specific codes has not been productive in detecting possible third party liability. You may receive authorization from HCFA to discontinue this activity for certain diagnosis and trauma codes. If you wish to exclude specific codes from being edited, request approval from the RO by submitting documentation which proves that pursuit of the specific code(s) has not been cost-effective.

The purpose of reviewing trauma codes is to detect potential casualty and liability claims and determine if another party is at fault. For example, if you determine that an injury resulted from a job-related accident, claims that have been submitted, as well as future claims for that accident, may be covered by workers' compensation.

Conduct these edits on a routine and timely basis and develop and specify in your State plan the frequency of the edits performed and the methods used for followup. Followup may involve contacting the recipient by phone or questionnaire to determine the nature of the trauma and then follow up with insurance companies, attorneys, witnesses, etc., to establish liability. After followup, incorporate all information that identifies legally liable third party resources into the eligibility case file, the third party data base and third party recovery unit as specified in §3903.4. Use this information to seek recovery from the liable third party. In addition, create an edit in the claims processing system and cost avoid future claims related to the injury, if appropriate, in accordance with §3904.1.

In addition to producing significant recoveries, the use of trauma edits to identify cases with recovery potential heightens the awareness of Medicaid's rules and regulations among the medical and legal communities. This produces the added benefit of increased numbers of voluntary referrals from providers, recipients, and attorneys.

3903.3 Data Exchanges--Conduct the following data exchanges in an automated fashion if possible:

A. State Wage Income Collection Agency (SWICA), SSA Wage and Earnings File, and State Title IV-A Agencies--You are required to have an income and eligibility verification system (IEVS). Under IEVS, certain wage and other relevant information from various agencies must be utilized for purposes of verifying Medicaid eligibility and the correct amount of medical assistance payments for applicants and recipients. In part, you are required to obtain State wage information from the SWICA, and self-employment, wage, and payment of retirement benefits information from the SSA wage and earnings file. For purposes of verifying income and eligibility, you are not required to follow up on all cases identified through the data exchange. You may target, for each data source, those items that are likely to be productive in identifying and preventing ineligibility and incorrect payment. (See Part 15, §15800.) For purposes of identifying third party resources, targeting does not apply.

The State IV-A agency is also required to conduct similar data exchanges for verifying income and eligibility for the Aid to Families with Dependent Children (AFDC) population. The IV-A agency is also permitted to target for purposes of verifying income and IV-A eligibility. The IV-A information may not be targeted for purposes of identifying third party resources.

For TPL purposes, IEVS data matches must include the names and SSNs of absent or custodial parents of recipients to the extent available. The match will identify Medicaid recipients, as well as absent or custodial parents of recipients, that are employed and their employer(s).

You must follow up on all information for the purpose of identifying legally liable third parties and incorporate such information into the eligibility case file, the third party data base and the third party recovery unit as specified in §3903.4 within 45 days from the date the data exchange was received, or as otherwise specified in 42 CFR 435.952(d). Every employment lead, no matter how small, could potentially be a lead for health insurance.

In most cases, followup would include contact with the identified individual's employer to obtain information regarding the availability of health insurance for the Medicaid recipient. This information should be gathered when the case worker is following up with an employer to verify income and eligibility requirements under IEVS regulations to avoid two employer contacts for the same individual. If the eligibility case file already contains information regarding health insurance available or not available through the individual's employer(s), additional followup is not necessary. Also, if you know that a particular employer does not provide health insurance at all or for particular categories of employees (e.g., employees who work less than 15 hours per week), you need not contact the employer each time. However, follow up periodically (once a year) with the employer to determine if they have changed their policy for providing health insurance.

Request from the State title IV-A agency information obtained from its SWICA and SSA wage and earnings file data exchanges which identifies AFDC/Medicaid recipients that are employed and their employer(s). If the IV-A agency has not followed up on the data to determine if the individuals have health insurance, you must conduct the followup. For TPL purposes, targeting does not apply to the IV-A agency data exchanges.

Use information identifying third parties to seek recovery if you have paid claims for which a third party is liable. In addition, create an edit in the claims processing system and cost avoid future claims in accordance with §3904.1.

If you can demonstrate to the RO that you have an alternate source of information that furnishes information as timely, complete and useful as the SWICA and SSA wage and earnings files in determining the legal liability of third parties, the requirements of this section are deemed to be met. However, you must follow up on all leads from these alternate matches in the same fashion as described above.

B. State Workers' Compensation or Industrial Accident Commission Files--Match identifying information; e.g., name, SSN for Medicaid recipients and (assuming names and SSNs have been obtained) absent or custodial parents of Medicaid recipients with Workers' Compensation or Industrial Accident files to identify those individuals with employment-related injuries or illness. A match with a Medicaid recipient may indicate that the individual was involved in a job-related injury and that worker's compensation or the Industrial Accident Commission may be liable for the cost for care and services furnished to the recipient. A match involving an absent parent or custodial parent could indicate that the parent is or was employed and that third party resources may be available through health insurance provided by the employer.

Follow up on the information for purposes of identifying legally liable third parties and incorporate such information into the eligibility case file, the third party data base and third party recovery unit as specified in §3903.4 within 60 days from the date the data exchange was received. Followup based on a match involving a Medicaid recipient may involve contacting the workers' compensation agency.

Followup based on a match with an absent parent may involve contacting the employed individual's employer. Use information identifying third parties to seek recovery if you have paid claims for which a third party is liable. In addition, create an edit in the claims processing system and cost avoid future claims, if appropriate, in accordance with §3904.1.

Secure an agreement (to the extent permitted by State law) with the State workers' compensation agency or the Industrial Accident Commission or submit documentation to the RO that demonstrates that you made a reasonable attempt to do so.

C. State Motor Vehicle Accident Report Files--Match identifying information for Medicaid recipients with State motor vehicle accident report files to identify those recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers, or passengers in motor vehicles, or as bicyclists. A match may indicate that third party resources would be available through an automobile or liability insurance policy.

Describe, as part of the State plan, your methods for following up on the information. Followup may include, but is not limited to, obtaining and reviewing police reports and interviewing witnesses to establish legal liability. After followup, incorporate all information that identifies legally liable third party resources into the eligibility case file, the third party data base and third party recovery unit as specified in §3903.4. Use information identifying third parties to seek recovery if you have paid claims for which a third party is liable. In addition, create an edit in the claims processing system and cost avoid future claims related to the accident, if appropriate, in accordance with §3904.1.

Secure an agreement (to the extent permitted by State law) with the State Motor Vehicle Department, or submit documentation to the RO that demonstrates that you made a reasonable attempt to do so.

3903.4 Incorporation of TPL Information into the Eligibility Case File, Third Party Data Base, and Third Party Recovery Unit--

A. Eligibility Case File--Incorporate into the eligibility case file health insurance information. The case file is the official audit trail for all TPL identification activity on a case, and should include all relevant information.

B. Third Party Data Base--Incorporate into the third party data base all health insurance information necessary to appropriately cost avoid claims. You must incorporate casualty and workers' compensation information into the third party data base after liability has been determined in order to cost avoid claims, unless you have evidence that there will be no future claims related to the injury.

C. Third Party Recovery Unit--Maintain in the third party recovery unit all information which is necessary to appropriately seek recovery of reimbursement. This includes casualty information and health insurance information if there are paid claims for which a third party is liable.

3903.5 Other Methods of Identification--Some States utilize various methods to identify third party resources in addition to the methods required by Federal regulations. There are numerous practices described in the Successful Practices Guide referred to in §3900.1. Examples of some State practices are:

A. Release of Information by Providers--Casualty-related third party resources not known to the State may be identified through requests for medical reports and bills received by providers from attorneys, insurance companies, and other parties. Some States require providers to contact the State agency before responding to such requests. This practice improves communications between providers and State agencies. What begins as a restriction on release of information evolves into a two-way inquiry/response process that improves relationships and claims processing efficiency.

B. Accident Related Third Party Resources Through Coordination with Ambulance Services--Ambulance services may provide to the State accident reports involving Medicaid recipients. When such reports are submitted timely, it can ensure the filing of claims and liens against third parties before damages are sought or payments made to the recipient.

C. Data Matches with Defense Eligibility and Enrollment Reporting System (DEERS)--DEERS is a centralized computer based system for confirming who is entitled to benefit programs administered by the DOD. The data base includes active duty personnel, retirees, surviving spouses and dependents. Data matches against DEERS will identify Medicaid recipients who are eligible for medical benefits under the military health care system which includes Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). HCFA coordinates all activities concerning the data matches. If you are interested in participating or would like information, write to:

Health Care Financing Administration
Office of Medicaid Management, BQC
Attention: Third Party Liability Branch, DPS
Room 273 East High Rise Bldg.
6325 Security Blvd.
Baltimore, MD 21207

3903.6 Agreement Between SSA, HCFA and State Medicaid Agencies is required in 1634 States (States in which SSA makes the SSI/Medicaid eligibility determination) that provides, in writing, for the collection from the applicant or recipient during the initial application and each redetermination process of health insurance information in the form and manner specified by the Secretary and for the transmittal of the information to the Medicaid agency. (See 42 CFR 433.138(b)(2).)

3903.7 Agreement Between the Medicaid Agency and Other State Agencies that Determine Medicaid Eligibility is required to provide for the collection from the applicant or recipient during the initial application and each redetermination process of such health insurance information as would be useful in identifying legally liable third party resources, and for transmittal of such information to you, so that you may process claims under the TPL payment procedure specified in 42 CFR 433.139(b) through (f). (See 42 CFR 433.138(b)(3).)

3903.8 SSNs of Absent or Custodial Parents, to the extent available, are required to be incorporated into the Medicaid eligibility case file and the third party data base by the State agency for the purpose of conducting data matches with SWICAs, the SSA earnings files, workers' compensation agency, and other sources. While you must, in connection with obtaining health insurance data, request the SSN of any person with legal responsibility (other than the applicant/recipient) for any member of the unit applying for or receiving benefits, you may not require that the applicant/recipient disclose SSNs other than his/her own as a condition of eligibility. When you request voluntary disclosure of SSNs, you must do so in accordance with section 7 of the Privacy Act, Public Law 93-579.

3903.9 Safeguarding of Information--Your State plan must provide safeguards that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. Regulations located at 42 CFR Part 431, Subpart F implement this requirement by specifying State plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and restrictions on the distribution of other information. Specifically, you must have criteria that govern the safeguards of information received and released in connection with the identification of legally liable third party resources. (See 42 CFR 431.305(b)(7).)

3904. PAYMENT OF CLAIMS (42 CFR 433.139)

3904.1 Cost Avoidance--Use the cost avoidance method unless you have a waiver, as described in §3904.2, or in specific situations described in §3904.4. Under the cost avoidance method, if you have established the probable existence of third party liability at the time the claim is filed, reject the claim and return it to the provider for determination of the amount of liability. The establishment of third party liability takes place when you receive confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, pay the claim to the extent that payment allowed under your payment schedule exceeds the amount of third party payment. (See 42 CFR 433.139(b).)

Program experience has indicated that, when third party resources are known or there is a reasonable expectation that they exist, it is usually more cost-effective for a State to use the cost avoidance method of claims payment than it is to use the pay and chase method. Areas of potential savings include:

- o Administrative savings from using fewer personnel and other resources to administer the filing of claims with third party payers and the resulting accounts receivable system;
- o Program savings from saved interest loss because Medicaid program dollars are not outstanding with the providers before the third party payment is received;
- o Administrative savings of claim processing costs for those claims that providers submit directly to the third party instead of to Medicaid;
- o Program savings from small dollar claims that are never submitted to a third party under "pay and chase," but which can be avoided altogether if a third party pays up front.

3904.2 Cost Avoidance Waivers--Federal regulations set forth at 42 CFR 433.139(e) provide the opportunity for States to seek a waiver of the required use of the cost avoidance method where it can be demonstrated that the pay and chase method is as cost-effective as the cost avoidance method. Usually, a separate waiver request should be submitted for each specific service or claim type for which a waiver is being sought; however, you may submit a single waiver package representing several services or claim types if the purpose, background, and rationale are the same for all services or claim types included in the package.

Cost avoidance waiver guidelines are provided for the purpose of assisting you in developing documentation to justify cost-effectiveness as specified in the regulations. Update and resubmit documentation every three years to substantiate that the pay and chase method continues to be as cost-effective as the cost avoidance method.

Use the following guidelines in submitting waivers.

A. Purpose.--Describe the specific type of claim or service to be waived.

B. Background.--Provide a historical analysis of this claim or service type which may include, but is not limited to, a description of the previous claims payment methodology, statistical data, or any other information that may provide background which would be helpful in making a determination.

C. Rationale.--Provide documentation which substantiates that the postpayment recovery method (i.e., pay and chase) is at least as cost-effective as the cost avoidance method. Base documentation on actual experience where applicable; otherwise, develop estimates. Fully explain the basis for the estimates. Base your determination of cost-effectiveness on the use of the best technology and practices reasonably and practicably available to the State.

Whether the waiver meets the conditions of cost-effectiveness is determined by, but not limited to:

- o Time, effort, and capital outlay required to perform cost avoidance versus pay and chase.
- o Examples of factors to be considered:

  - Volume
  - Average cost per claim
  - Denial rate
  - Benefit limitation parameters
  - Administrative costs
  - Contractor costs
  - Salaries
  - Overhead
  - Equipment/computer costs

- o Startup costs will generally not be considered.

3904.3 Recovery--Seek reimbursement from third parties whenever you have paid claims for which there are third parties that are liable for payment of the claims. This is referred to as the "pay and chase" method. Reimbursement must be sought unless it is determined that recovery of reimbursement would not be cost effective in accordance with threshold amounts that have been established. (See §3904.5.)

If the probable existence of TPL cannot be established or third party benefits are not available to pay the recipients medical expenses at the time the claim is filed, pay the full amount allowed under your payment schedule. If you learn of the existence of a third party after you have paid the claim, or benefits become available from the third party after the claim is paid, seek recovery of reimbursement from the third party to the limit of legal liability within 60 days from the end of the month in which you learn of the existence of the third party or benefits become available, whichever is later.

Take whatever action is necessary to meet the 60 day requirement for seeking recovery of reimbursement. If you have established threshold amounts in accordance with §3904.5, initiate recovery action for all claims within 60 days from the end of the month after reaching the accumulated threshold amount. In situations where periodic interim payments are made to providers, make an entry in your accounting system within 60 days of learning that benefits have been paid to the provider by the third party after Medicaid payment was made for the same services. Include these recovery amounts due the State in your end-of-year adjustments.

After you have billed a third party, track the status of payments targeted for recovery and follow up with the third party if you do not receive a response within a reasonable amount of time. One method is to generate a letter to the third party every 90-120 days if you have not received an appropriate response.

There are specific situations in which you are required to use the pay and chase method of payment, even though there is a known third party at the time a claim is filed. These situations involve claims for Medicaid recipients who have been provided medical support as a result of a court order, and claims involving pregnancy-related and preventive pediatric services. (See §3904.4.)

Use the pay and chase method if you have an approved waiver as specified in §3904.2. If you have an approved waiver and you pay the claim, you must seek recovery from the third party within 60 days after the end of the month in which payment is made. Such a waiver does not preclude you from using the cost avoidance method, however.

When you adopt an aggressive recovery stance, all other parties involved in the process (i.e., providers, attorneys, casualty firms, private health insurers, and recipients) tend, over time, to cooperate voluntarily with State procedures and policies.

3904.4 Mandatory Use of Pay and Chase--There are specific circumstances where cost avoidance must not be used. Use the pay and chase method in accordance with established thresholds whenever these conditions exist:

A. Medical Support Enforcement--Pay and chase claims in situations where the TPL is derived from a parent whose obligation to pay support is being enforced by the State title IV-D agency and the provider has not received payment from the third party within 30 days after the date of service. The intent of this requirement is to protect the custodial parent and his/her dependent children from having to pursue the absent spouse, and his/her employer or insurer, for TPL.

Choose whether or not providers will be required to bill a third party in this situation. Ensure that when a provider does bill Medicaid, the provider indicates whether a third party has been billed. If you require providers to bill the third party first, and you receive a bill from a provider who has not billed the third party, return the claim to the provider or wait until 30 days have elapsed from the date of service to process the claim for payment in accordance with your normal payment schedule. If you do not require a provider to bill the third party, pay the full amount allowed under your payment schedule and seek reimbursement from the third party.

For situations when the provider does bill a third party first, have a method in place to monitor that the provider did not receive payment from the third party prior or subsequent to billing Medicaid. You may require hard copy documentation that identifies the third party, and certifies that the third party has been billed and payment has not been received.

In some cases, such as when electronic billing is used, it may not be cost effective to require hard copy certification. Pay the claim and follow up to assure that providers have complied with billing requirements. When you contact a third party to seek recovery, you can verify whether or not the provider received payment from the third party and failed to report it to you.

B. Prenatal and Preventive Pediatric Care--You must pay and chase in situations where the claim is for prenatal care for pregnant women or preventive pediatric services (including EPSDT services) that are covered under the State plan.

The intent of this requirement is to alleviate the administrative burden associated with TPL efforts so as not to discourage participation in the Medicaid program by physicians and other providers of these types of services, since beneficiaries in need of such services already have difficulty finding providers in many communities.

In order to carry out the intent, it may be necessary to pay and chase claims for pregnancy-related services other than prenatal care (i.e., labor and delivery and post-partum care). The pay and chase method may be used for pregnancy-related services other than prenatal care whenever it is determined that using the cost avoidance method would discourage provider participation.

For instance, the same practitioner that provides the prenatal care often handles the labor and delivery and post-partum care. Generally, the practitioner bills for the entire range of obstetrical services in a lump sum amount; prenatal is not broken out from the labor and delivery and post-partum care. The administrative burden placed on providers of changing their billing practices and requiring them to bill a third party for the labor and delivery and post-partum care only could adversely affect access to prenatal care. You have the option to pay and chase for the entire range of pregnancy-related services. However, you must continue to cost avoid claims associated with the inpatient hospital stay for labor and delivery and post-partum care.

The following exhibits are provided as guidelines for determining certain claims for which you must use the pay and chase method. The first exhibit includes diagnosis codes related to prenatal care. The second exhibit includes diagnosis codes related to preventive pediatric care. These diagnosis codes were selected since it would be impractical to identify every procedure code which could relate to prenatal and preventive pediatric care. In order to identify prenatal claims which must be paid and chased, use the appropriate procedure codes related to these diagnoses. These guidelines define the terms prenatal and preventive pediatric care narrowly. You have the option of defining these terms more broadly. For example, the definition of prenatal care may be expanded to include preexisting conditions which are likely to affect the pregnancy.

Prenatal Care Services

ICD-9-CM Diagnosis Codes (Volumes 1 and 2)

Prenatal care is defined as services provided to pregnant women if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy. The types of claims involved would be claims for routine prenatal care, prenatal screening of mother or fetus, and care provided in the prenatal period to the mother for complications of pregnancy.

Code	Description	Routine Prenatal Care	Prenatal Screening of Mother or Fetus	Complicat Pregnancy Prenatal P (applies to provided t
V22.0, V22.1	Supervision of normal pregnancy	x		
V23	Supervision of high risk pregnancy			x
V28	Antenatal screening		x	
640-648	Complications related to pregnancy			x
*651-658 671, 673, 675-676	Other conditions requiring care in pregnancy	x	x	

* Claims must be paid and chased unless the fifth digit is a 2 or 4.

Preventive Pediatric Care Services

ICD-9-CM Diagnosis Codes (Volumes 1 and 2)

Preventive pediatric care is defined as screening and diagnostic services to identify congenital physical or mental disorders, routine examinations performed in the absence of complaints, and screening or treatment designed to avert various infectious and communicable diseases from ever occurring in children under age 21. This includes immunizations, screening tests for congenital disorders, well child visits, preventive medicine visits, preventive dental care, and screening and preventive treatment for infectious and communicable diseases.

Code	Description	Immunizations and Communicable Diseases	Screening Tests for Congenital Disorders	Well Child or Preventive Medicine Visits	Preventive Dental Care	Scre Trea
VO1	Contact with or exposure to communicable disease					
VO2	Carrier or suspected carrier of infectious disease					
VO3-VO6	Need for prophylactic vaccination against bacterial, viral, and other communicable diseases	x				
VO7	Need for isolation & other prophylactic measures	x				
V20	Health supervision of infant or child			x		
V70.0	Routine general medical examination			x		
V72.0-.3	Routine examination of specific organ system			x		
V73-V75 V77.0-.7 V78.1-.3 V79.2-.3 V79.8 V82.3-.4	Special screening exams/tests for infectious & communicable diseases or congenital defects		x			

3904.5 Threshold Amounts--Suspend or terminate efforts to seek reimbursement from a liable third party if you determine the activity would not be cost effective. Also, the State plan must:

o Specify the threshold amount or other guideline to use in determining whether to seek reimbursement from a liable third party; or describe the process by which you determine that seeking reimbursement would not be cost effective. Documentation of a cost-effective measurement must be provided for States with thresholds greater than $100 for health insurance and greater than $250 for casualty claims.

o Specify a dollar amount or period of time for which you will accumulate billings with respect to a Medicaid recipient or particular liable third party in making the decision whether to seek recovery. An example would be to accumulate pharmacy claims for a 60-day period, or until a set threshold is achieved before billing the third party.

Low thresholds may result in pursuing claims which cost more to process than will be recouped. Conversely, if thresholds are too high, you lose money. Most States utilize thresholds under $50 for health insurance and $100 for casualty claims. Accumulate claims that fall under the threshold; when the total meets the threshold, send claims to the third party for recovery.

3904.6 Federal Financial Participation (FFP) and Repayment of Federal Share (42 CFR 433.140).--FFP is not available if:

o You fail to take the reasonable measures to determine the legal liability of third parties. (See §3903.)

o You fail to seek reimbursement from liable third parties. (See §3904.)

o A private insurer would have been obligated to pay for the services except that its insurance contract limits or excludes payments for Medicaid eligible individuals.

o You received reimbursement from a liable third party. Whenever this occurs, repay the Federal government the amount of FFP received as payment for claims which were subsequently reimbursed by a third party. The payment may be reduced by the amount of incentive payments discussed in §3906.

3904.7 Medicaid Payment to Providers Who Offer Discounts to Third Party Payers.--Some providers enter into agreements with third party payers to accept payment for less than the amount of charges. These arrangements are often referred to as "preferred provider agreements" or "preferred patient care agreements."

Whenever you are billed for the difference between the payment received from the third party based on such an agreement and the charges, do not make Medicaid payment. The provider's agreement to accept payment of less than its charges constitutes receipt of a full payment for its services, and the insured has no further responsibility. Medicaid is intended to make payment only where there is a recipient legal obligation to pay.

3905. ASSIGNMENT OF RIGHTS TO BENEFITS - (42 CFR 433.145)

The requirement for mandatory assignment of rights must be included in the Medicaid State plan as provided by §1902(a)(45) of the Act. A plan must provide that, as a condition of eligibility, each legally able applicant and recipient:

- o Assigns his/her rights and the rights of any other eligible individuals for whom the individual has the legal authority under State law to assign such rights, to medical support or other third party payments to the agency;

- o Except for poverty level pregnant women (see §3311 ff), cooperates with you, in the absence of good cause, in establishing paternity and obtaining medical support or payments; and

- o Cooperates, in the absence of good cause, in identifying and providing information to assist you in pursuing liable third parties.

3905.1 Rights Assigned (42 CFR 433.146).--The applicant or recipient must make a written assignment assigning his/her rights to any medical support available under an order of a court or an administrative agency. He/she must also assign to you any third party payments for medical care and payments for any other individual eligible under the plan for whom he/she has the legal authority under State law to make an assignment.

The rights to Medicare benefits may not be assigned. The individual may assign Medicare payments to the provider. This results in the provider being paid directly by Medicare rather than the individual receiving and forwarding the payment.

In some instances, Federal law restricts assignment of insurance. 31 U.S.C. 3727 prohibits the assignment of claims against the United States.

The only exception to that rule is the assignment before two witnesses of a claim that has been approved, for which a warrant for payment has been issued, and the assignment of which is approved by an officer having authority to acknowledge deeds. That exception does not authorize the kind of blanket assignment of rights to medical support contemplated under §1912 of the Act. Therefore, assignment of benefits covered by §1912 of the Act cannot be required.

If an applicant refuses to make an assignment of benefits as a condition of Medicaid eligibility, Medicaid does not pay for any services for that individual.

3905.2 Method of Assignment (42 CFR 433.146(c)).--If assignment of rights to benefits is automatic because of State law, you may substitute such an assignment for an individually executed one if you inform the individual of the terms and consequences of State law.

A State subrogation law must meet the requirement mandating assignment of rights as a condition of eligibility upon an applicant filing for Medicaid. States utilizing a subrogation law are required to notify applicants of the terms and consequences of the statute. As a means of efficient administration of the program, you may choose to utilize a single assignment form for both child support and medical support purposes for applicable recipients. If you choose this option, clearly explain to the recipient the dual purpose of the form.

SSA continues to determine Medicaid eligibility of applicants and recipients for Supplemental Security Income (SSI) in States which have entered into agreements under §1634 of the Act.

SSA gives an oral explanation to all applicants of the assignment of rights requirements and advises that it is a condition of eligibility for Medicaid. The explanation also advises that the applicant must cooperate with the Medicaid agency in establishing paternity and obtaining medical support payments from third party payers, and cooperate in identifying and providing information to assist the State in pursuing any liable third party.

For initial determinations, SSA annotates an SSI application and provides the Medicaid agency with a code and date indicator via the State Data Exchange (SDX) for purposes of showing whether the individual has assigned his/her rights and whether the individual has cooperated in identifying and providing third party information in States which have a §1634 agreement. During the redetermination process, SSA determines if the recipient continues to meet the conditions of eligibility for Medicaid. SSA annotates the SSI redetermination form and provides the Medicaid agency with a code and date indicator via the SDX. The specific codes for assignment of rights and cooperation are:

A = Refused to assign rights
R = Refused to provide third party information
Y = Assigned rights and provided third party information
N = Assigned rights and does not have third party coverage

In States where assignment of rights is not automatic under State law upon an applicant's filing for Medicaid, SSA has each applicant sign a form showing an explanation of the assignment of rights, and that he/she assigns such rights. In States where assignment of rights is automatic under State law, SSA provides applicants an oral explanation of the assignment of rights and cooperation provision, without requiring written execution of assignments, if requested by a State.

3905.3 Cooperation in Establishing Paternity and Obtaining Support and Cooperation in Identifying and Providing Third Party Information (42 CFR 433.147).

A. Establishing Paternity and Obtaining Support.--Except for poverty level pregnant women (see §3311 ff), require the individual to cooperate in establishing the paternity of a child born out of wedlock for whom the individual can legally assign rights and in obtaining medical care support and medical care payments for himself/herself, as well as for any other person for whom the individual can legally assign rights.

B. Identifying and Providing Third Party Information.--Require the individual to cooperate in identifying and providing information to assist you in pursuing any third party which may be liable to pay for care and services available under the plan. Individuals are not required to pursue collections themselves. Pursuit is the responsibility of the provider or the State.

C. Good Cause for Non-cooperation.--The conditions of paragraphs A. and B. must be met unless such individual has good cause for not cooperating as determined by you in accordance with the standards prescribed in paragraph E.

D. Cooperation may Require the Individual to:

o Appear at a State or local office designated by you to provide information or evidence relevant to the case;

o Appear as a witness at a court or other proceeding;

o Identify liable third parties and provide information, or attest to lack of information, under penalty of perjury;

o Pay to you any support or medical care funds received covered by the assignment of rights; and

o Take any other reasonable steps to assist in establishing paternity and securing medical support and payments.

E. Waiver of Cooperation for Good Cause.--You may waive the requirements for cooperation if you determine that the individual has good cause for refusing to cooperate. To do so, you must find that cooperation is against the best interests of the individual, child, or other person as specified in current regulations at 42 CFR 433.147(c)(2). Determine whether good cause for noncooperation exists, based on the factors established by the AFDC child support enforcement program at 45 CFR 232.40-232.49. The criteria to use in situations involving children (including establishment of paternity) are listed in the Child Support Enforcement Program at 45 CFR, Part 232 and §302.31. You are not required to submit your findings to the State IV-A agency director for review and approval. However, some form of communication is required in order to discover whether the IV-A agency has made a good cause finding. (See 42 CFR 433.147(c)(1).)

Circumstances which constitute "good cause" for noncooperation exist if:

o The person for whom support is sought was conceived as a result of incest or rape;

o Legal proceedings for adoption are pending;

o The question of whether to place the child for adoption is under active consideration; or

o Cooperation is reasonably anticipated to result in:

-- Physical or emotional harm (an emotional impairment that substantially affects the individual's functioning) to the Medicaid recipient or other person for whom the Medicaid recipient has authority to assign rights for TPL; or

-- Physical or emotional harm to the person who has responsibility for cooperating.

Furnish Medicaid services to an otherwise eligible recipient pending resolution of whether a waiver should be granted, if the applicant or recipient meets all other eligibility requirements and has submitted the requested evidence to determine good cause.

Make good cause determinations for SSI and noncash recipients. When the State title IV-A agency makes a good cause finding for a AFDC/Medicaid recipient, adopt that finding as your own.

Pursuant to 45 CFR 232.40(b), prior to requiring cooperation, notify the applicant or recipient of the right to claim good cause as an exception. The notice must include advising the applicant or recipient that good cause may be claimed and that corroborative evidence must be furnished. Specify that the applicant or recipient may be requested to provide sufficient information to permit an investigation to determine the validity of the good cause claim.

Several separate determinations of good cause may be required in the same case (e.g. cases involving several children with different parents, or where the spouse and parent are different individuals).

With regard to obtaining medical care support and payments for an individual other than a child, adopt procedures similar to those specified in 45 CFR, Part 232, excluding those applicable only to children. Consider as minimum requirements: (See 45 CFR 232.40-232.46.)

o Inform the individual that a claim for good cause may be made for refusing to cooperate;

o Advise the individual of the grounds for claiming good cause and the evidence needed to support such a finding;

o Review the evidence submitted, conduct any additional investigation warranted, and reach a determination as promptly as possible;

o Make payments for Medicaid furnished to an otherwise eligible individual pending a determination whether good cause exists if the individual has submitted the evidence requested; and

o Make a determination that good cause exists only if the evidence establishes that the required cooperation is not in the best interests of the individual or other person who has the legal authority to assign rights.

3905.4 Denial or Termination of Eligibility (42 CFR 433.148).--Individuals who fail to meet the assignment provisions including assignment of rights to benefits and cooperation must be denied Medicaid eligibility. Deny eligibility, or terminate if already certified, any applicant or recipient who:

o Refuses to assign his own rights or those of any other individual for whom he can legally make an assignment;

- Except for poverty level pregnant women (see §3311 ff), refuses to cooperate in establishing paternity and obtaining medical support and payments; or

- Refuses to cooperate in identifying and providing third party information (unless cooperation has been waived for good cause).

Provide Medicaid to any individual who cannot legally assign his/her own rights and is otherwise eligible for Medicaid but for a refusal to assign the individual's rights or refusal to cooperate by a person who has the legal authority under State law to assign his/her rights. For example, if a mother refuses to assign benefits for herself and her children (for whom she can legally make an assignment) or refuses to cooperate, only the mother becomes ineligible for Medicaid. The children remain eligible. However, if a mother with a newborn refuses to assign rights or to cooperate, both the mother and the newborn are ineligible, since the newborn's eligibility is dependent upon the mother's eligibility. A new application must be filed on behalf of the newborn to establish eligibility on his/her own behalf as a child. (See §3305.)

In denying or terminating eligibility, comply with the notice and hearing requirements in 42 CFR Part 431, Subpart E.

3905.5 Handling Situations Where SSI/Medicaid Applicants and Recipients Refuse to Assign Rights or Refuse to Cooperate.--When an individual has refused to assign his/her rights or to cooperate, the Social Security district office (DO):

- Advises the individual that SSA cannot complete the determination or redetermination for medical assistance;

- Refers the individual to the State Medicaid agency; and

- Annotates the SSI application or redetermination form indicating refusal to assign rights and/or refusal to cooperate.

If the individual contacts the State Medicaid agency, ascertain the reason for refusal to assign rights and/or cooperate. If you determine that the individual has good cause for refusing to cooperate (see §3905.3.E.) or if the individual changes his/her mind and agrees to assign his/her rights and to cooperate, he/she is eligible for Medicaid benefits provided he/she is also eligible for SSI benefits.

Inform the SSA DO of any changes which affect the code indicator shown in the SDX. If SSA has not completed the SSI application process, refer the individual back to the SSA DO. The DO executes the assignment and/or collects the health insurance information.

If SSA has completed the SSI application process:

- Execute the assignment and/or collect the health insurance information.

- Advise the DO to make the necessary changes to the code and date indicators on the SDX.

If the individual does not contact you and you become aware of a refusal code via the SDX, notify the individual that eligibility is being denied. In denying or terminating eligibility, comply with the notice and hearing requirements in 42 CFR Part 431, Subpart E.

3905.6 Recommendations for Referring Medicaid Recipients to Child Support Enforcement (CSE) Agencies.--CSE agencies are required to provide all CSE services (without an application or fee) to all families with an absent parent who receive Medicaid and have assigned to the State their rights to medical support. The CSE agencies are required by 45 CFR 303.31 to petition for medical support when health insurance is available to the absent parent at a reasonable cost. For these agencies to provide the required services, they must know who these individuals are. Therefore:

o Coordinate with the CSE agency to ascertain the needed information. The type of information collected and the method of transmitting the data may vary from State to State.

o Solicit specific information from Medicaid recipients to determine if they are eligible for CSE services and for transmission to the title IV-D agency unless:

--The recipient already has satisfactory health insurance other than Medicaid;

--The recipient is receiving adequate medical support from the absent parent; or

--The Medicaid agency has a cooperative agreement for the enforcement of rights to medical support with an entity other than the title IV-D agency.

o Refer cases to the CSE agency once you have determined that individuals may be eligible for their services. Do not refer pregnant women until after the child is born.

Refer to the SDX to identify SSI/Medicaid recipients who may qualify for CSE services. Use the recipient type code field to identify recipients who are blind or disabled children. (For a listing of the specific codes, refer to the Program Operations Manual System, §02601.305, issued by SSA). Upon identifying a blind or disabled child, follow up with the recipient or the recipient's representative to determine if an absent parent situation exists. If so, collect the necessary information and refer the case to the CSE agency.

AFDC regulations (see 45 CFR, Parts 232 and 235.70) set forth their program requirements for collecting and referring information to the CSE agencies. Use these regulations as guidelines for referring Medicaid only cases to the CSE agencies.

3905.7 Requirements of Title IV-D Agency in Obtaining Medical Support. (See 45 CFR 306.50 and 306.51 (to be redesignated as Subpart A of Part 306 effective October 1, 1990).)--Title IV-D agencies are required to:

o Obtain basic medical support information, if available, and provide this information to the State Medicaid agency (if it is not already being provided by the title IV-A or title IV-E agency) for use in TPL activities. If the individual requesting services is a Medicaid applicant or recipient, the title IV-D agency is required to secure the:

- Name, address and SSN of the absent parent;

- Name and address of the absent parent's place of employment;

- Name and SSN of child(ren);

- AFDC or title IV-E foster care case number, Medicaid number, or custodial parent's SSN; and

- Policy name(s) and number(s) and names of persons covered if the absent parent has any health insurance policies.

o Petition the court or administrative authority, in new and amended court orders, to require the absent parent to provide health insurance for dependent children whenever it is available to the absent parent at reasonable cost. (Health insurance is defined to be reasonable in cost if it is employment-related or other group health insurance.) This includes petitioning for medical support whether or not it is actually available to the absent parent at the time the order is entered or modified;

o Identify existing child support cases which have a high potential for obtaining medical support and petition the court or administrative authority to modify support orders to include medical support for targeted cases even if no other modification is anticipated;

o Inform you of any new or modified support orders that include a medical support obligation;

o Take steps to enforce the health insurance coverage required by a court or administrative order;

o Provide you with health insurance policy information whenever it becomes available (i.e., at the time services are being requested, at the time the order is entered or modified, or when the absent parent secures health insurance coverage under the order);

o Communicate with the Medicaid agency to determine if there have been lapses in health insurance coverage for Medicaid applicants and recipients; and

o Request employers and other groups offering health insurance coverage that is being enforced by the title IV-D agency to notify the title IV-D agency when the absent parent§s health insurance coverage lapses.

3905.8 Responsibility of Medicaid State Agency in Obtaining Medical Support Information from Title IV-D Agency.--Contact the title IV-D agency immediately if you have not already done so to arrange for the timely and efficient exchange of the information identified in §3905.7. Maintain contact with the title IV-D agency on an ongoing basis to ensure the timely flow of required information.

3906. COOPERATIVE AGREEMENTS AND INCENTIVE PAYMENTS

A. Cooperative Agreement. (See 42 CFR 433.152.)--A State plan must provide for entering into written cooperative agreements for enforcement of rights to and collection of third party benefits with at least one of the following entities: the State title IV-D agency, any appropriate agency of any State, and appropriate courts and law enforcement officials.

o The terms are left to your discretion.

o Agreements with title IV-D agencies must specify that the title IV-D agency§s reimbursement from the Medicaid agency is limited to services beyond the requirements specified in 45 CFR Part 306 Subpart B.

o The removal of the detailed requirements from the cooperative agreements does not change the specific requirements of the Office of Child Support Enforcement (OCSE) under 45 CFR Part 306 governing cooperative agreements between State child support enforcement agencies and State Medicaid agencies.

o Retain final responsibility for TPL collection functions that are not covered by cooperative agreements.

Failure to obtain an agreement does not relieve you of medical enforcement responsibility.

B. Incentive Payments. (See 42 CFR 433.153.)--Make an incentive payment to a political subdivision, a legal entity of the subdivision such as a prosecuting or district attorney or friends of the court, or another State that enforces and collects medical support and payments for you under a cooperative agreement.

Enforcement may be defined as a pursuit of medical support against someone other than the Medicaid recipient, or against some source, such as an insurance company, which is responsible for medical services provided to a recipient by virtue of its responsibility to an absent responsible relative. It includes actions taken against responsible relatives to insure provision of health insurance coverage for Medicaid recipients, as well as pursuit of benefits from third parties which are based on insurance policies held by legally responsible relatives. Enforcement does not include pursuit of third parties based on insurance policies held by Medicaid recipients themselves. Collections is defined as amounts collected from sources who are responsible for medical services provided Medicaid recipients, including benefits received as the result of premiums paid by an absent responsible relative. Collections do not include amounts collected for premiums.

Enforcement and collection activity must be controlled by a cooperative agreement if FFP to the extent of the incentive payment is allowed. If a locality or another State performs only enforcement or collection activities, but not both, no incentive payment under 42 CFR 433.153 is allowed. States may make incentive payments from State only funds.

Incentive payments cannot be made under 42 CFR 433.153 when a State makes a collection itself. The purpose of the incentive payment is to encourage local participation and to encourage cooperation between States. Thus, when a State makes a collection itself, an incentive payment is not appropriate, since there is no involvement of a locality of the State. A State which makes a collection itself shares in the benefits of the collection through the reimbursement it receives for the State share of payment.

The incentive payment must equal 15 percent of the amount collected. It is made from the Federal share of that amount.

If more than one State or political subdivision is involved in enforcing and collecting support and payments:

- Pay the incentive payment to the political subdivision, or another State that collected medical support and payments at your request; and

- The political subdivision, legal entity or other State that receives the incentive payment divides the incentive payment equally with any other political subdivisions, legal entities, or other States that assisted in the collection unless an alternative allocation is agreed upon by all jurisdictions involved.

3906.1 Requirements of State CSE Agency and Cooperative Agreements.--Title IV-D regulations in 45 CFR Part 306 contain the requirements applicable to the State CSE agency with respect to medical support enforcement and the requirements applicable to cooperative agreements between you and the State CSE agency.

3906.2 Funding.--You are responsible for reimbursement to the State CSE agency for any activities performed under the agreement that are necessary for the collection of amounts for the Medicaid program. This includes activities the CSE agency is required to perform under its regulations.

The Medicaid FFP rate for activities contained in a cooperative agreement with the State CSE agency is 50 percent. Therefore, claim your full reimbursement to the State CSE agency as an administrative expense on the quarterly statement of expenditures.

Activities performed by a CSE agency that are not under a cooperative agreement with the Medicaid agency are reimbursed under title IV-D.

3907. DISTRIBUTION OF COLLECTIONS

Distribute collections to:

- Yourself, an amount equal to State Medicaid expenditures for the individual on whose right the collection was based;

- The Federal Government, the Federal share of the State Medicaid expenditures, minus any incentive payment; and

- The recipient, any remaining amount. SSI policy states that refunds of medical insurance payments made by a Medicaid agency are not income to recipients. Therefore, this refund is not considered income for aged, blind or disabled Medicaid recipients in States which use SSI criteria. However, the refund is considered a resource in the month after it is received.

AFDC program policy states that a refund of medical insurance payments made to a recipient is considered income. Therefore, the refund is considered income to AFDC-related Medicaid recipients. States may permit providers to collect directly from third party resources.

In liability situations, the Medicaid program must be fully reimbursed before the recipient can receive any money from the settlement or award. This is based on §1912(b) of the Act and 42 CFR 433.154. Legitimate costs of obtaining the settlement or award, such as attorney fees, may be deducted prior to reimbursement to the Medicaid program.

3908. CONFLICTING CLAIMS BY MEDICARE AND MEDICAID

Under §1862(b) of the Act (see 42 U.S.C. 1395y(b)), Medicare payments may not be made, to the extent that payment has been made, or can reasonably be expected to be made, for Medicare covered items or services under:

- A workers' compensation law or plan of the United States or a State;

- An automobile, no-fault, or any liability insurance policy or plan (including a self-insured plan); or

- An employer group health plan for employed beneficiaries age 65 or over and the spouses aged 65 and over of employed individuals of any age.

Also, with regard to beneficiaries entitled to Medicare solely on the basis of end stage renal disease (ESRD), payment may not be made for Medicare covered items or services during a period of up to 12 months to the extent that payment for these items or services has been, or will be, made by an employer group health plan as promptly as would otherwise be the case if payment were made by Medicare.

Any Medicare payment for items or services under §1862(b) of the Act is conditioned on reimbursement to the appropriate Trust Fund when notice or other information is received that payment for those items and services is made under such a law, policy, plan or insurance. Under the law, Medicare has the right to recover its benefits from employers and workers' compensation carriers, liability insurers, automobile or no fault insurer, and employer group health plans before any other entity, including a State Medicaid agency. Also Medicare has the right to recover its benefits from any entity, including a State Medicaid agency, that has been paid by any of these third parties. In other words, Medicare's recovery rights where any of these third parties is primary payer, are higher than and take precedence over the rights of any other entity.

The superiority of Medicare's recovery right over those of other entities, including Medicaid, derives from §1862(b) of the Act, which provides that where Medicare is secondary to another insurer:

- HCFA may recover Medicare benefits from the responsible insurer;

- HCFA may recover its payments from any entity that has been paid by the responsible insurer; and

- HCFA is subrogated to the right of the Medicare beneficiary and the right of any other entity to payment by the responsible insurer.

Subrogation literally means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the responsible insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary for services covered by the insurer. Medicare can be a party to and participate in any claim by a beneficiary or other entity against the insurer, can participate in negotiations concerning the total insurance payment and the amount to be repaid to Medicare, and may seek recovery of conditional payments directly from the responsible insurer.

If Medicare and Medicaid both have claims against any of these third parties, Medicare's right to recover its benefits from the third party or from a beneficiary/recipient that has been paid by the third party is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort, and therefore, does not pay its benefits until after Medicare has paid. Medicare's priority right of recovery does not violate the concept of Medicaid's being payer of last resort. Under §1862(b) of the Act, Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) where payment can reasonably be expected by any of these third parties. Where the third party pays right away, Medicare makes no payment to the extent of the third party payment. Delay of third party payment does not change Medicare's ultimate obligation to pay the correct amount regardless of any Medicare payments conditionally made. Thus, where the third party pays less than the charges, Medicare may be responsible to pay secondary benefits. And where the third party pays the charges, Medicare may not pay at all. Pro-rata or other sharing of recoveries with Medicaid has the effect of creating a Medicare payment where none is authorized under the law, or improperly increasing the amount of the Medicare secondary payment.

The right of Medicaid agencies to recover their benefits derives from an assignment by Medicaid recipients to the States of their rights to third party payments. Since the recipient can assign to the State a right no higher than his own, and since Medicare's statutory right is higher than the recipient's, Medicare's right is higher than that assigned to the State.

Thus, where Medicare and Medicaid have 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 any other entity, including a State Medicaid agency, may be paid.

Also, where a beneficiary/recipient, attorney, provider or supplier receives payment from the third party for services which have already been paid for by Medicare and by Medicaid, and the amount paid by the third party is less than the combined amounts paid by Medicare and Medicaid, the payee is obligated to refund the Medicare payment up to the full amount of the third party§s payment, despite a conflicting claim by a State Medicaid agency. Only after Medicare has recovered the full amount of its claim does the beneficiary/recipient, attorney, provider or supplier have the right to reimburse Medicaid or any other entity.

If the third party has reimbursed a State Medicaid agency, or if a beneficiary/recipient, after receiving a payment from the third party, has reimbursed a State Medicaid agency, the State agency must reimburse Medicare up to the full amount the agency received if Medicare is unable to recover its payment from the remainder of the third party payment. If the State 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 State, recovery of Medicare benefits is achieved by offset of Medicare's claim against any Federal financial participation funds otherwise due the State.

3909. MEDICARE/MEDICAID CROSSOVER CLAIMS

Medicare/Medicaid crossover claims are claims for services in which both the Medicare and Medicaid programs are involved because an individual is entitled to Medicare and eligible for Medicaid. Crossover claims may involve Part A Medicare services, Part B Medicare services purchased under a buy-in agreement, or Part B Medicare services outside the context of a buy-in agreement, which are also covered under a Medicaid State plan. Crossover claims may also involve Medicare services which are not covered under Medicaid. These instructions apply to crossover claims where the Medicare beneficiary is also eligible for Medicaid, but does not qualify as a Qualified Medicare Beneficiary (QMB). (See §3490 for QMB crossover claims.)

Participation in the Medicaid program is limited by 42 CFR 447.15 to providers who accept, as payment in full, the amounts paid by the Medicaid agency, plus any cost sharing amount (recipient liability) authorized under the State Medicaid plan. You are not responsible for paying more than the applicable payment rate established in your State plan. A Medicaid recipient's liability, if any, for services covered under the Medicaid program is limited by §1916 of the Act to "nominal" amounts. In addition, §1902(a)(25)(C) of the Act further limits a recipient's liability for services where a third party, such as Medicare, is liable forpayment, and prohibits a provider from seeking to collect from the recipient any amount in excess of the recipient's liability.

Effective for physicians' services furnished on or after April 1, 1990 to a Medicare beneficiary who is also eligible for medical assistance, Medicare payment may only be made on a Medicare assignment-related basis. Thus, the provider must accept Medicare assignment for physicians' services if the Medicare beneficiary is Medicaid eligible. In addition, Medicare sanctions may be applicable if a person knowingly and willfully bills for physicians' services in violation of this restriction.

Medicaid is the payer of last resort; therefore, when an individual is entitled to Medicare and eligible for Medicaid, Medicare, like other third parties, is the primary payer. After the amount of Medicare's liability is determined, pay the claim up to the amount of the Medicaid rate, only to the extent that the Medicaid rate exceeds the amount of Medicare's liability and that an obligation remains on the part of the Medicaid eligible, but only up to the upper limits specified in the regulations. For example, as specified in 42 CFR 447.304, payments made under the plan for deductibles and coinsurance payable on an assigned Medicare claim for noninstitutional services may be made only up to the reasonable charge under Medicare, even if the payment amount in the State plan is higher. An exception to the upper payment limits in 42 CFR 447.272(c) allows States to make Medicaid payments in excess of the Medicare cost principles to hospitals designated as those serving a disproportionate share of low-income patients with special needs.

In establishing the applicable payment schedule amount for payment of Medicare Part A and Part B deductibles and coinsurance for Medicare/Medicaid crossover claims, you have the option of setting the applicable payment amount at the rate paid when the recipient is not also a Medicare beneficiary, or you can choose to set a higher amount up to the Medicare allowable rate. This means that, after deducting Medicare's liability for the service, you are paying part or all of the amount of the Medicare deductible and coinsurance. Your payment amount for Medicare/Medicaid crossover claims must be reflected in the State plan.

Following are examples of several situations showing your responsibility and the recipient's responsibility for payment of Medicare cost sharing amounts for services which are covered under Medicare and also covered under the Medicaid State plan. In each of the example, the Medicare deductible is met unless otherwise indicated.

Example 1

Medicare rate for service (amount allowed without regard to deductible and coinsurance)	=	$ 100
Medicare pays (80 % of rate for service) (TPL)	=	80
Medicare coinsurance (amount not paid by Medicare)	=	20
Medicaid rate for service (No recipient copayment imposed by Medicaid)	=	$ 100
Medicaid pays	=	$ 20
Medicaid recipient liability	=	0

Example 2

Medicare rate for service	=	$ 100
Medicare pays (80%) (TPL)	=	80
Medicare coinsurance (amount not paid by Medicare)	=	20
Medicaid rate for service (No recipient copayment imposed by Medicaid)	=	$ 80
Medicaid pays	=	0
Medicaid recipient liability	=	0

Example 2 assumes that the State has not set a separate rate for the service for Medicare beneficiaries eligible for Medicaid. If the State wishes to pay some or all of the Medicare cost sharing amounts, it could set a separate rate for the service for these individuals at the Medicare allowed charge or between the Medicare allowed charge and the normal Medicaid rate. If the State paid the full cost sharing amount, the result is as described in Example 1.

Example 3

Medicare rate for service	=	$ 100
Medicare pays (80 %) (TPL)	=	80
Medicare coinsurance (amount not paid by Medicare)	=	20
Medicaid rate for service ($95 + $5)	=	$ 100
Medicaid copayment for service	=	5
Medicaid pays	=	$ 15
Medicaid recipient liability	=	5

Example 4

Medicare rate for service	=	$ 100
Medicare pays (80%) (TPL)	=	80
Medicare coinsurance (amount not paid by Medicare)	=	20
Medicaid rate for service ($65 + $5)	=	$ 70
Medicaid copayment for service	=	5
Medicaid pays	=	0
Medicaid recipient liability	=	0

Example 5

Medicare rate for service	=	$ 100
Unmet Medicare deductible	=	65
Medicare pays (80 % of $35 ($100-$65=$35)) (TPL)	=	28
Medicare coinsurance (amount not paid by Medicare)	=	7
Medicaid rate for service ($95 + $5)	=	$ 100
Medicaid copayment for service	=	5
Medicaid pays	=	$ 67
Medicaid recipient liability	=	5

Example 6

Medicare rate for service	=	$ 100
Unmet Medicare deductible	=	65
Medicare pays (80 % of $35 ($100-$65=$35)) (TPL)	=	28
Medicare coinsurance (amount not paid by Medicare)	=	7
Medicaid rate for service ($75 + $5)	=	80
Medicaid copayment for service	=	5
Medicaid pays	=	$ 47
Medicaid recipient liability		5

Example 7

Medicare rate for service	=	$ 100
Medicare pays (80 %) (TPL)	=	80
Medicare coinsurance (amount not paid by Medicare)	=	20
Medicaid rate for service ($78 + $5)	=	$ 83
Medicaid copayment for service	=	5
Medicaid pays	=	0
Medicaid recipient liability	=	3

3909.1 State Buy-In of Part B Benefits (See 42 CFR 431.625).-- If you have a buy-in agreement to enroll certain Medicare-eligible recipients under Medicare Part B, you are required to pay their premiums. This entitles the recipient to the entire range of Medicare Part B benefits. However, your payment of the premiums under a buy-in agreement does not obligate you to cover, or to pay deductibles and coinsurance for, the entire range of Medicare Part B benefits. With respect to deductibles and coinsurance, you have the following options:

A. Option 1.--You may elect to pay Medicare cost sharing amounts only for those Medicare Part B services which are covered in your Medicaid plan even if the total amount paid for these services (composed of the Medicare and the Medicaid payments) exceeds the Medicaid rate employed for this service for Medicaid only eligibles. You obtain this result by establishing a separate higher rate for the service for Medicare beneficiaries eligible for Medicaid. (This rate may not be limited only to individuals who receive Medicare under a buy-in agreement.)

B. Option 2.--You may elect to pay Medicare cost sharing amounts for the entire range of Medicare Part B benefits, whether or not they are covered under your State plan. With respect to covered services, you are subject to conditions contained in the last two sentences of Option 1.

C. Option 3.--You may elect to pay Medicare cost sharing amounts for all those Medicare Part B services which are covered under your plan as well as some Part B services which are not covered under your plan, but for which you specify that you pay the Medicare cost sharing. With respect to covered services, you are subject to the conditions contained in the last two sentences of Option 1.

For those Part B benefits covered under your plan,your payment of deductible and coinsurance amounts is subject to the applicable payment schedule amounts in your plan for Medicare (Part B)/Medicaid crossover claims, as indicated in §3909.

If you elect not to pay toward deductibles and coinsurance for Part B benefits not covered in your plan, the recipient is still eligible for the Part B benefits from Medicare, but, is considered only a Medicare beneficiary with respect to these benefits and is liable for the Medicare deductibles and coinsurance for services not covered under Medicaid. However, you may elect to pay any amount toward deductibles and coinsurance for part or all of the Part B benefits not covered in your plan.

3910 MEDICAID PAYMENTS FOR RECIPIENTS UNDER GROUP HEALTH PLANS

3910.1 General.--Section 4402 of OBRA 1990 added §1906 to the Act to provide for the mandatory enrollment of Medicaid eligibles in cost effective group health plans as a condition of Medicaid eligibility. Section 4741 of the Balanced Budget Act (BBA) of 1997 amended § 1902(a)(25) and 1906(a)(1) of the Act making this provision optional, effective August 5, 1997.

3910.2 Affected States.--This requirement applies to the 50 States and the District of Columbia.

3910.3 Definitions.--

Group Health Plan--This is a plan which meets §5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to title XXII of the Public Health Service Act, §4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974. Section 5000(b)(1) of the Internal Revenue Code provides that a group health plan is any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees.

Cost Effectiveness--The amount you pay for premiums, coinsurance, deductibles, other cost sharing obligations under a group health plan, and additional administrative costs is likely to be less than the amount paid for an equivalent set of Medicaid services.

3910.4 State Plan Requirements.--If elected a State plan must:

o Provide a methodology for determining the likely cost effectiveness of an individual's enrollment in a group health plan;

o Provide for payment of all premiums, deductibles, coinsurance and other cost sharing obligations under the group health plan for Medicaid recipients enrolled in the group health plan for items and services under the State plan;

o Provide for payment of items and services provided to Medicaid recipients under the State plan that are not covered in the group health plan;

o Provide for payment of premiums for non-eligible family members only if it is necessary in order to enroll a Medicaid eligible family member in the group health plan and it is likely to be cost effective to do so; and

o Treat the group health plan as a third party resource in accordance with third party liability requirements in §§3900-3909 except Federal financial participation (FFP) is available as provided in §3910.6.

A State may require, as a condition of eligibility, enrollment in a group health plan where the enrollment is likely to be cost effective (except for an individual who is unable to enroll on his/her own behalf.)

3910.5 Condition of Eligibility.--If a State elects to pay for cost effective group health plans, the State may require individuals, who are eligible to enroll in a group health plan the State determines to be cost effective, to enroll in that group health plan to obtain or maintain their Medicaid eligibility. The State must make an exception to this requirement where an individual who is otherwise eligible for Medicaid, is unable to enroll in the group health plan on his/her own behalf. For example, if a parent refuses to enroll the child, or a spouse is unable to enroll freely on his/her own behalf, such failure does not affect the child's or spouse's eligibility to Medicaid benefits.

The fact that an individual is enrolled in a group health plan does not change the individual's eligibility for benefits under the State plan. If Medicaid services covered under the State plan are not part of the services covered by an eligible individual's group health plan, the individual may obtain those services from participating Medicaid providers. These services are reimbursed at the State Medicaid rate.

3910.6 Availability of FFP.--FFP is available for the payment of premiums for Medicaid eligible enrollees in a cost effective group health plan. FFP is also available for all deductibles, coinsurance and other cost sharing obligations under the group health plan that are for services covered under the State plan, except for the nominal cost sharing amounts otherwise permitted under §1916 of the Act which are the recipient's responsibility.

If a non-Medicaid eligible family member must be enrolled in the group health plan in order to obtain coverage for the Medicaid eligible member, FFP is available for premiums only (no other cost sharing expenses) for the non-Medicaid eligible family member(s). A family member may reside in a separate household.

If an individual's group health plan offers more services than covered under the State plan, no FFP is available for the deductibles, coinsurance and other cost sharing obligations for non-covered services.

If a Medicaid recipient is also eligible for Medicare Part B and is not enrolled in Part B, no FFP is available for the payment of premiums or other cost sharing obligations to the group health plan.

If a Medicaid recipient is currently enrolled in a non-employer based group health plan and is also eligible to enroll in a cost effective group health plan as described in this section, the State may require the recipient to enroll in the cost effective group health plan to maintain his/her Medicaid eligibility. If enrollment in both health plans remains cost effective, then FFP is available for the cost sharing obligations of the non-employer based plan per §1903(a) of the Act.

3910.7 Guidelines for Enrollment.--Group health plans usually limit an individual's enrollment period. If an individual, who is already enrolled in a group health plan, becomes Medicaid eligible, the State may buy into the plan as of the effective date of Medicaid eligibility. Eligibility for Medicaid may be effective no later than the third month before the month of application as described in 42 CFR 435.914.

If a Medicaid recipient is not eligible for coverage under a group health plan for a specified waiting period, the State may buy into the plan as of the effective date of eligibility. Until the recipient is eligible to enroll, or entitled to receive services under the group health plan, all covered services are paid under applicable Medicaid procedures for group health coverage.

If the State elects to pay for cost effective group health plans, §1906(a)(3) of the Act requires you to pay the premiums that an enrollee is required to pay. This type of payment is most often obtained through payroll deductions and some employers may refuse to provide health insurance unless it is paid for through that means. Therefore, where enrollees make payment through payroll deductions, reimburse the enrollee for the payment. An individual is only required to enroll in a group health plan if the plan is cost effective. Whenever a periodic Medicaid redetermination is done, the cost effectiveness of the group health plan must be reevaluated.

3910.8 Guidelines for Disenrollment.--If a State elects to require enrollment in a cost effective group health plan as a condition of eligibility, an affected individual may disenroll in that group health plan only when the employer offers more than one cost effective group health plan and the employee applies for enrollment in a different cost effective group health plan. Where only one group health plan is available, and you determine that it is cost effective, disenrollment from the plan results in the termination of Medicaid eligibility. This ineligibility remains effective until the next open season for group health plan enrollment.

If the availability for enrollment in the group health plan and eligibility to Medicaid benefits do not coincide, have the applicant apply (by completing necessary forms) for enrollment in the group health plan at the time of Medicaid application. Hold the enrollment application for the group health plan until open season, then submit the form. The applicant is not eligible for Medicaid benefits if he/she refuses to apply for enrollment in a group health plan during the Medicaid application process. This ineligibility remains effective until the next open season for group health plan enrollment.

3910.9 Non-Medicaid Providers.--Some providers that participate in group health plans may not be Medicaid participating providers. Although §1902(a)(25)(C) does not appear to limit providers to Medicaid participating providers, encourage all providers to become Medicaid participating providers. Provider participation may be initiated solely through the submission of a bill for services as is currently permitted for Qualified Medicare Beneficiaries (QMBs). If providers refuse to bill Medicaid, consider the option of direct payment to recipients.

3910.10 Optional Minimum 6-Month Eligibility.--You may deem a minimum enrollment period of up to 6 months in cost effective group health plans for Medicaid eligibles. If recipients lose their eligibility to Medicaid benefits before the end of the 6 month period, you may continue entitlement to the plan from the effective date of the individual's enrollment to the end of the deemed period. During this period, FFP is limited to premiums, deductibles, coinsurance and other cost sharing obligations for benefits provided under the group health plan. The individual is not entitled to any Medicaid benefits provided outside of the group health plan. Specify the minimum enrollment period in your State plan.

3910.11 Cost Effectiveness.--An individual's enrollment in a group health plan is considered cost effective when the amount you pay for premiums, coinsurance, deductibles, other cost sharing obligations, and additional administrative costs is likely to be less than the Medicaid expenditures for an equivalent set of services. The methodology for determining cost effectiveness must be included in the State plan and approved by HCFA. Submit documentation demonstrating a reasonable approach to any suggested methodology. Your methodology may include factors not presented in our guidelines, e.g. considering a recipient's diagnosis. The following guidelines are one way to determine cost effectiveness.

Step 1-Policy Information.--Obtain information on the group health plan available to the recipient. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy and premiums paid by the employee.

Step 2-Average Medicaid Costs.--Using the Medicaid Management Information System (MMIS), obtain the average total annual Medicaid costs of persons like the applicant (age, sex, category and geographic data).

Step 3-Medicaid Costs for Included Services.--Determine the amount of the total yearly Medicaid expenditures that are spent on the services covered by the individual policy. For example, assume that 10 services are covered under the State plan and 6 of those 10 are covered by the group health plan, but those 6 are the most frequently used services under both the group health plan and the Medicaid State plan. Compute the percentage of expenditures for group health plan services to the expenditures for Medicaid services. In this example, assume that the services comprise 82 percent of the Medicaid expenditures which are covered by this group health plan. Then adjust the average total annual Medicaid costs specified in step 2 by this percentage.

Step 4-Group Health Plan Costs for Included Services.--Adjust the Medicaid average covered expense amount (amount from step 3) for the higher prices employer plans typically pay. You may use a single State specific factor that is derived from your experience with TPL or use group health plan specific information. Alternatively, a national average factor may be used. This factor is supplied and updated by HCFA periodically. Once this factor is determined, the Medicaid covered expense is multiplied by this factor to produce an estimated covered expense as recognized by the employer plan.

Step 5-Adjustment for Coinsurance and Deductible Amounts.--The health plan cost (amount from step 4) is multiplied by an average employer health insurance payment rate to obtain the employer recognized covered expense amount. Derive the average employer health insurance payment rate from State specific tables, if available, or group health plan specific information. Alternatively, for your use, national tables are supplied and updated by HCFA periodically. This average payment rate number varies by how large the average employer recognized covered expense is.

Step 6-Administrative Costs.--Account for additional administrative costs to Medicaid for processing the group health information by determining the average increase in cost per recipient.

Step 7-Cost Effectiveness Calculation.--Compare the costs under the group health plan to those costs under Medicaid.

Group Health Plan

- Subtract the employer recognized covered expense (step 5) from the costs of services under the group plan (step 4);
- Add the employee's share of premiums paid (step 1); and
- Add the additional administrative costs (step 6).

Medicaid Expenditures.--Use the average Medicaid cost for the services covered under the group health plan (step 3).

Cost effectiveness is likely if your cost under the group health plan is lower than your cost for the same services under Medicaid. (See example on determining cost effectiveness.)

NOTE: When non-Medicaid eligible family members are enrolled in group health plans in order to enroll the Medicaid eligible member, do not include the deductibles, coinsurance and other cost sharing obligations for the non-Medicaid eligible family members in your calculations.

3910.12 Effective Date.--The enrollment date of a Medicaid eligible individual in a group health plan is the effective date for benefits made by these amendments. However, in no case are benefits effective prior to January 1, 1991. The optional provision at §4741 of the BBA of 1997 is effective August 5, 1997.

3910.13 Comparability of Services.--Section 1902(a)(10) of the Act has been amended to allow Medicaid coverage for the costs of premiums, deductibles, coinsurance and other cost sharing obligations for individuals in cost effective group health plans without requiring the availability of comparable services of the same amount, duration, and scope to other Medicaid eligibles.

3910.14 Determination and Redeterminations of Eligibility.--Determination and redeterminations of eligibility are subject to the rules in 42 CFR 435.911 and 916.

3910.15 Erroneous Excess Payments.--You are not charged errors with respect to payments made in violation of §1906 of the Act.

Example of Cost Effectiveness Guidelines

Step 1-Policy Information.--Obtain information on the group health plan available to the Medicaid recipient. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy and premiums paid by the employee.

Individual: Ms. Smith, aged 25, AFDC, county X
Daughter, aged 6, AFDC, county X

Group Health plan: Effective date 1/1/91
No exclusions
6 Covered Services - Hospital Inpatient, Hospital Outpatient, Physician Services, Clinic, Laboratory and X-ray, and Prescription Drugs

Premiums: $840.00 yearly

Step 2-Average Medicaid Costs.--Using the Medicaid Management Information System (MMIS), obtain the average total costs per person per year for Medicaid services to persons like the applicant (age, sex, category and geographic data).

MMIS Data: 25 year old female, AFDC, county X =	$1,550.00
6 year old female, AFDC, county X =	1,250.00
Total Medicaid Expenses	$2,800.00

Step 3-Medicaid Costs for Included Services.--Determine the amount of the total yearly Medicaid expenditures that are spent on the services covered by the individual policy.

10 Services offered under the State plan:

Inpatient Hospital	Outpatient Hospital
Clinic	Laboratory and X-ray
SNF and Home Health	EPSDT
Physician Services	Family Planning services
Physical Therapy	Prescription Drugs

6 Services offered under the group health plan:

Inpatient Hospital	Outpatient Hospital
Clinic	Laboratory and X-ray
Physician services	Prescription Drugs

The services covered by the health plan are the most frequently used services. These 6 services happen to comprise 82 percent of the Medicaid costs in the example State. On an average annual basis, the costs to Medicaid of providing the 6 services offered under the group health plan are:

Ms. Smith's expenses at 82%	$1,271.00
Daughter's expenses at 82%	1,025.00
Medicaid average covered expense amt.	$2,296.00

Step 4-Group Health Plan Costs for Included Services.--Adjust the Medicaid average covered expense amount (amount from step 3) for the higher prices employer plans pay. Use a single State specific factor that is derived from your experience with TPL, or use group health plan specific information. For the purpose of this example, the national factor of 1.3 was used. Once this factor is determined, the Medicaid covered expense is multiplied by this factor to produce an estimated covered expense as recognized by the employer plan.

Medicaid average covered expense amount	$2,296.00
National average factor	X 1.30
Actuarial value of group health plan services if there were no cost sharing or service limitations	$2,984.80

Step 5-Adjustment for Coinsurance and Deductible Amounts.--The health plan cost (amount from step 4) is multiplied by an average employer health insurance payment rate to obtain the employer recognized covered expense amount. Derive the average employer health insurance payment rate from State specific tables, national tables, or group health plan specific information. Assume the number is 75 percent for the purposes of this example. This average payment rate number varies by how large the average employer recognized covered expense is.

Cost to health plan for services	$2,984.80
Average employer payment rate (75%)	X .75
Employer recognized amount	$2,238.60

Step 6-Administrative Costs.--Account for additional administrative costs to Medicaid for processing the group health information by determining the average increase in cost per recipient.

Increased cost to process info.	$ 50.00
Number of recipients	x 2.00
Additional admin. costs	$100.00

Step 7-Cost Effectiveness Calculation.--Compare the costs under the group health plan to those costs under Medicaid.

Cost to group health plan (step 4)	$2,984.80
Employer recognized amt. (step 5)	-2,238.60
Proxy for deductibles, coinsurance and limitations within types of service covered under the group health plan	$ 746.20

Employee's premiums (step 1)	+ 840.00
Additional admin. costs (step 6)	+ 100.00
Total costs to State under group health plan	$1,686.20
Costs to State from Medicaid for these services	$2,296.00

Cost effectiveness is likely if the costs to the State under the group health plan is lower than the cost to the State for these services under Medicaid.

Costs to State from Medicaid for these services	$2,296.00
Costs to State under group health plan	-1,686.20
Savings from group health plan	$ 609.80