



SMD # 23-002

RE: Third-Party Liability in Medicaid: State Compliance with Changes Required in Law and Court Rulings

March 8, 2023

Dear State Medicaid Director:

The Center for Medicaid and CHIP Services (CMCS) is issuing this State Medicaid Director Letter (SMDL) to provide guidance to state Medicaid agencies on two new third-party liability (TPL) requirements reflected in current law. The first new provision was included in the Consolidated Appropriations Act, 2022 (CAA, 2022; P.L. 117-103) and increases state flexibility with respect to TPL by requiring states to have laws in effect that bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules. The second change in TPL requirements came with the U.S. Supreme Court ruling in *Gallardo v. Marstiller* that the Social Security Act (the Act) permits a state to create a lien over injury settlement proceeds attributable to future medical expenses.

Background

Medicaid is generally the “payer of last resort,” meaning that Medicaid only pays claims for covered items and services if there are no other liable third-party payers for the same items and services. When Medicaid beneficiaries have one or more additional sources of coverage for health care services, TPL rules govern the legal obligation of such third parties. Section 1902(a)(25)(A) of the Act defines third-party payers as health insurers, managed care organizations, and group health plans, among others.

Federal law generally requires health insurers and other third parties legally liable for health care services received by Medicaid beneficiaries to pay for such services. Federal law also requires states to have state laws enhancing the states' ability to identify and obtain payment from third-party resources that are legally responsible to pay claims primary to Medicaid.

Consolidated Appropriations Act of 2022

The CAA, 2022, enacted March 15, 2022, increases state flexibility with respect to TPL. Section 202 of the CAA, 2022 amended section 1902(a)(25)(I) of the Act to require a state plan for medical assistance to provide assurances satisfactory to the Secretary that the state has state laws in place that bar responsible third-party payers (other than Medicare plans) from refusing payment for an item or service solely on the basis that such item or service did not receive prior

authorization under the third-party payer’s rules.¹ Specifically, if the responsible third party requires prior authorization for an item or service furnished to a Medicaid-eligible individual, the responsible third party must accept the authorization provided by the state that the item or service is covered under the state plan (or waiver of such plan) for such individual, as if such authorization was made by the third party for such item or service. *Authorization by the state* means that the item or service an individual received (and for which third-party reimbursement is being sought) is a covered service or item under the Medicaid state plan (or waiver of such plan) for that individual.

Section 202 of the CAA, 2022 also modifies the existing requirement for a third-party payer to respond to a state inquiry regarding a health care claim that is submitted not later than three years after the provision of such item or service to specify that the third party must respond within 60 days of receiving the inquiry.

The effective date for this new provision is January 1, 2024, with an exception for states that first need to pass state legislation to comply with the change in law. States must submit a state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) providing assurances that the required laws are in effect in the state. Some states may already have the requisite laws. These states should submit an amendment to their state plan to CMS as soon as practicable. States that do not currently have the laws mandated by the CAA, 2022 should enact the required legislation during their next legislative session and submit a SPA to CMS by the end of the legislative session.

Gallardo v. Marsteller

On June 6, 2022, the U.S. Supreme Court ruled in *Gallardo v. Marsteller* that section 1917 of the Act permits a state to create a lien over injury settlement proceeds attributable to future medical expenses.² Specifically, the Court held the Act’s assignment-of-rights provision at section 1912(a)(1)(A) does not limit a beneficiary’s assignment of medical support and payment of medical care from a third party to the Medicaid program to payments for *past* medical care already paid for by Medicaid. The Court reasoned that this provision includes the beneficiary’s assignment to payment for past medical expenses, and also includes rights to payment for future medical expenses. The Court said that, because a state may seek reimbursement from settlement amounts representing payment for past or future medical care under section 1912(a)(1)(A), the anti-lien provision at section 1917(a) of the Act does not apply to state laws that permit a state to recover reimbursement for Medicaid’s payment of a beneficiary’s past medical expenses by taking funds from the portion of the beneficiary’s settlement amounts for future medical expenses.

This case revisits similar issues presented in *Wos v. E.M.A.* (2013) and *Arkansas Dept. of Health and Human Services v. Ahlborn* (2006). Those cases interpreted Medicaid’s anti-lien provisions as saying states may only recover the medical expense portion of an injury settlement, as opposed to pain and suffering, lost wages, and other property rights recovered. In *Gallardo*, the

¹ See Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, Division H, Title II, Section 202 (“Increasing State Flexibility with Respect to Third Party Liability”).

² See *Gallardo v. Marsteller*, No. 20-1263 (2022)

Supreme Court held that the *Wos* and *Ahlborn* rulings do not conflict just because one is broader than the other, and that a state may recover its Medicaid payments only from the portion of the settlement, judgment, or award designated for medical expenses.

As a result of the *Gallardo v. Marstiller* ruling, states may now pursue recovery for medical care furnished on behalf of a beneficiary not only from the portions of the beneficiary's settlement representing compensation for past Medicaid-furnished care but also from settlement funds that compensate the Medicaid beneficiary for future medical care.

Additional Information

If you have any questions about this SMDL, please contact Ginger Boscas, Deputy Director, Division of Health Home, PACE, and COB/TPL at Ginger.Boscas@cms.hhs.gov.

Sincerely,

/s/

Daniel Tsai
Deputy Administrator and Director