September 11, 2000

Dear State Medicaid Director:

The purpose of this letter is twofold. We want to remind you of the cost-avoidance requirements of the Federal Regulations at 42 CFR 433.139(b), and to alert you to the two enclosed Program Memoranda (PMs) issued May 2000 to Medicare intermediaries and carriers on "Written Statements of Intent to Claim Medicare Benefits" and "Claims Processing Instructions for Claims Submitted With a Written Statement of Interest".

For services and supplies covered by both the Medicare and Medicaid programs, Medicare is a primary payer to Medicaid, and Medicaid is the payer of last resort. Normally, these cost-avoidance requirements indicate that Medicaid may not pay a claim submitted by a provider or supplier before Medicare, unless:
(1) the state has an approved cost-avoidance waiver for these claims; or (2) it is evident that there is no Medicare eligibility, coverage, or payment, and the provider or supplier furnishes such confirmation to Medicaid (42 CFR 433.139(b)(1)).

We recognize that it is not always feasible or efficient for all dual eligible claims to be submitted to Medicare before Medicaid may pay for the service or supply, especially in cases where it is evident that the service or supply is not covered by Medicare. Screening a claim may indicate to a provider, supplier, or to the state that there is no Medicare liability based on Medicare eligibility and coverage requirements. Acceptable confirmation previously submitted for similar claims may be considered precedent and again utilized.

However, sometimes you will discover Medicare eligibility or coverage of a service or supply after you have paid the Medicaid claim. When you discover that an individual is entitled to Medicare, or that Medicare benefits are available after a claim has been paid by Medicaid, you are required to seek recovery of expenditures from the third party to the limit of legal liability within 60 days after the end of the month you learn of Medicare entitlement or the availability of Medicare benefits (42 CFR 433.139(d) (2)). This should be an ongoing process and should not wait until immediately prior to the expiration of the Medicare claims filing period. Waiting until just prior to the end of the claims filing period to seek recovery of Medicaid expenditures may create a hardship on providers and suppliers, as well as on Medicare contractors, and may result in claims being denied as untimely.

Despite adherence to the above time limits for filing a Medicare claim, sometimes you will not be able

to file a Medicare claim until just prior to the expiration of the claims filing period. State Medicaid agencies may submit a "statement of intent to claim Medicare benefits" (described below) in limited situations, such as when Medicaid has paid the claim because, at the time the claim was

filed with Medicaid, Medicare entitlement was unknown or Medicare benefits were not available. The enclosed PMs provide information concerning statements of intent submitted to Medicare intermediaries and carriers by state Medicaid agencies or parties authorized to act on their behalf. The purpose of a statement of intent is to extend the timely filing period for Medicare claims. We want to emphasize that a statement of intent, by itself, does not constitute a claim, but rather, is a placeholder for filing a timely and proper Medicare claim, as indicated in the enclosed PMs. The PMs also detail Medicare's policy for accepting a statement of intent and the deadlines for submitting a subsequent valid claim for benefits. This policy is applicable for the claims filing period ending December 31, 2000, and for claims filing periods thereafter.

Following the above cost-avoidance procedures should limit the number of statements of intent that state Medicaid agencies must file, and will produce more rapid reimbursement by Medicare to the state Medicaid agency, and will result in less hardship for providers. Failure to follow these procedures in Medicare/Medicaid dual eligible cases may result in inappropriate Medicaid payments for services or supplies that could be paid initially by Medicare. When the state Medicaid agency or a contractor for the state pursues third party recovery for inappropriate Medicaid expenditures, the procedures necessary to seek recovery from Medicare result in additional burden and expense to providers and suppliers and the state and Federal governments, and often result in lost savings to both the Medicare and Medicaid programs. We strongly encourage states to educate providers and suppliers to screen claims and to determine whether the requirements for Medicare eligibility, coverage, and payment are met, to bill Medicare or Medicaid correctly and in a timely manner, and to provide acceptable confirmation of a third party's liability.

We anticipate further Program Memoranda being issued to Medicare intermediaries and carriers concerning additional information on the coordination of Medicare and Medicaid benefits for dual eligibles. We will provide you with this information as it becomes available.

Questions about the contents of this letter should be directed to Robert Nakielny at (410) 786-4466 or Rnakielny@hcfa.gov.

Sincerely,

/S/

Timothy M.
Westmoreland
Director

Enclosures

AB-00-43
AB-00-51

cc:

All HCFA Regional Administrators All HCFA Associate Regional Administrators for Medicaid and State Operations Lee Partridge - Director, Health Policy Unit, American Public Human Services Association Joy Wilson - Director, Health Committee, National Conference of State Legislatures Matt Salo - Director of Health Legislation, National Governors' Association <% 'Sitewide navigation info / do NOT edit %>