7108 Third Party Liability (02/01/2003, 02-33)

Medicaid is the payer of last resort, after all third party medical resources have been applied. A third party is defined as one having an obligation to meet all or any portion of the medical expense incurred by the beneficiary for the time such service was delivered. Such obligation is not discharged by virtue of being undiscovered or undeveloped at the time a Medicaid claim is paid; it then becomes an issue of recovery (see rule 7108.2). Medicaid beneficiaries are required to follow all rules of their third party insurance. Medicaid will not pay claims that have been denied by the third party insurer for failure to follow their rules. Some examples of third party medical resources are:

- Medicare;
- Health insurance, including health and accident but not that portion specifically designated for "income protection" which has been considered in determining beneficiary eligibility to participate in the Medicaid program;
- Medical coverage included in conjunction with other benefit or compensation programs such as military and veteran programs, and worker's compensation; and
- Liability for medical expenses as agreed or ordered in negligence suits, support settlements, trust funds, etc.

7108.1 Health Insurance Premiums (02/01/2003, 02-33)

The commissioner may elect at any time to require an applicant or beneficiary to enroll, or remain enrolled, in a private health insurance plan, provided that such enrollment meets the conditions specified in this section and in rule 4138.4 and, in the commissioners judgment, is likely to be cost-effective and in the department's best interest. If enrollment is required, the department will pay the individual's share of the health insurance premium.

Once an individual has met this requirement by enrolling or remaining enrolled in a health insurance plan, Medicaid will cover the full array of Medicaid services and items, provided that the rules of their health insurance plan have been followed.

7108.2 Adjustment or Recovery (02/01/2003, 02-33)

The department may take action either before or after Medicaid payment of a claim to assure appropriate disbursement of Medicaid funds when payment turns out to be inappropriate due to subsequently discovered resources, fraud, error, or the development of third party-liability. Taking administrative action and accepting partial or full reimbursement shall not preclude either simultaneous or subsequent action in civil or criminal court as appropriate.

The department may:

A. negotiate adjustment or recovery on a voluntary basis with recipient, provider, or an obligated third party;

B. accept adjustment or recovery in conjunction with the imposition of provider sanctions (see rule 7106.4);

C. file a lien against any third party to recover Medicaid expenditures from any settlement, judgment, or other income that may be awarded through negligence liability action;

D. enter direct civil action to effect adjustment or recovery when other efforts fail; or

E. investigate and prepare for referral to the appropriate criminal prosecutor any case presumed subject to adjustment or recovery by way of such action.

Providers may be required to enter a claim against any subsequently discovered health insurance resources previously unknown or overlooked and submit an adjusted Medicaid claim upon collection, with reimbursement as appropriate.

7108.3 Estate Recovery (02/01/2003, 02-33)

The department shall seek adjustment or recovery from the estates of individuals who died on or after January 1, 1994 provided that the individuals were 55 years of age or older when they received long-term care services paid for by the Medicaid program for nursing facility services, home-and-community-based waiver services, and related hospital and prescription drug services. Related hospital and prescription drug services are those paid for by the Medicaid program during a period of time when the individual is living in a nursing facility or enrolled in a home-and-community-based waiver program. Adjustment or recovery shall include amounts in personal needs accounts.

The department will file a claim with the probate court as a creditor of the estate to recover its expenditures for long-term care services only after the death of an individual's surviving spouse, if any, and when the individual has no surviving child who is under age 21, or blind, or permanently and totally disabled as defined by the Social Security Administration.

7108.3.1 Exemptions from Estate Recovery

The department exempts the following assets from estate adjustment or recovery when an heir requests an exemption in writing no later than four months after the publication of notice to creditors of the estate.

A. Homes in trust prior to December 1, 1997:

The department normally recovers for long-term care Medicaid costs incurred after January 1, 1994. Individuals with homes in revocable trusts who received Medicaid payment of long-term care services before December 1, 1997, however, are exempt from recovery until after May 1, 1998, or, if later, the effective date of the first Medicaid eligibility review completed after December 1, 1997.

B. When loss of assets would present an undue hardship:

The department will not seek adjustment or recovery from assets when that adjustment or recovery would present an undue hardship to the decedents family members, as specified below and in rule 7108.3.

1. Income-producing assets

Undue hardship exists when adjustment or recovery from an income-producing asset can be made only if the asset, alone or in combination with other related assets, is sold and either or both of the following conditions are met:

a. The assets sold are the sole source of income for the decedents spouse, parents, children, or siblings.

b. As a result of the sale, the decedents spouse, parents, children, or siblings would qualify for public assistance (Reach Up benefits, SSI/AABD, general or emergency assistance, or TANF or TANF/MOE benefits from another state).

C. Estates with personal property valued at less than $2,000:

The department will not seek recovery where the estate inventory filed with the probate court consists only of personal property that does not exceed $2,000 in value, such as home furnishings, apparel, personal effects, and household goods.

The department will not seek to recover assets for which the department has imposed a penalty period of ineligibility for Medicaid coverage of long-term care services related to the transfer of those assets.

7108.3.2 Hardship Exemptions for Homesteads

At any time before closure of the probate estate, an heir may assert that adjustment or recovery against the homestead would be an undue hardship and that the homestead should be exempt from adjustment or recovery for the costs of Medicaid long-term care services. The department shall exempt a decedents home from estate adjustment or recovery based on undue hardship when one or more of the following three conditions have been established to the departments satisfaction.

A. A sibling has been living in the home continuously for at least one year immediately before the date the decedent began receiving long-term care services.

B. A son or daughter has been living in the home continuously for at least two years immediately prior to the date the decedent began receiving long-term care services and provided care that allowed the decedent to remain at home.

C. Conditions (1), (2), and (3) below have been met.

1. The fair market value of the homestead is less than $250,000. If the fair market value of the homestead exceeds this amount, the first $250,000 in fair market value shall be exempt from estate recovery and any equity value in excess of $250,000 shall be subject to the provisions of rule 7108.3.

2. A sibling or lineal heir of the deceased Medicaid beneficiary will inherit the homestead. A lineal heir is a direct descendant, such as a child or grandchild.

3. The heir meets one or both of conditions (a) and (b) below.

a. The heir has gross family income below 300 percent of the federal poverty level. No income exclusions or deductions are allowed. The income of the persons presented in the following table is included in the heirs gross family income, provided that they are living in the heirs household.

Heir's Household

Type of Heir	Family Members, If Living in the Heirs Household
Adult 18 years or older; or person younger than 18 and emancipated	Heir Heirs spouse or civil union partner Heirs biological or adoptive child or stepchild
Person younger than 18 and not emancipated	Heir Heirs parent Heirs stepparent Heirs biological or adoptive sibling, stepsibling, or half sibling, if younger than 18 and not emancipated

b. The heir demonstrates that significant services or financial support provided to the deceased person by heirs meeting condition (2) or the spouses of such heirs enabled the person to avoid long-term care or delay it at least six months. It is not necessary for the deceased person to have been a Medicaid beneficiary when the services or financial support were provided. Services may have been provided in combination with services provided by governmental or other private entities.

To meet condition (b), the services or financial support must fall into one or both of the following two categories:

i. Medical or remedial care or support services that were:

- medically necessary;
- provided directly by the heir or the heir's spouse without compensation, or purchased with the heir's funds; and
- provided while the deceased person required medical care and services consistent with the level of care standard for level III residential care homes at a frequency averaging no fewer than three times per week or, if provided less frequently, constituting the equivalent expenditure of time or money.

The department shall not verify the level of care unless it has a reasonable basis for questioning that the level III standard was met.

ii. Other services or financial support at least as significant as the care or services described in category (i).

When there are two or more heirs, the full value of the homestead is exempt from Medicaid estate adjustment or recovery only if each heir meets conditions (1), (2), and (3) above. When one or more heirs do not meet conditions (1), (2), and (3), the percentage of the value of the homestead corresponding to their share is subject to Medicaid estate adjustment or recovery.

7108.3.3 Adjusting Claims Against Homesteads

An estate includes all real and personal property and other assets listed on an inventory filed in the probate court. The probate court oversees the distribution of assets to heirs and the payment of the decedent's outstanding debts, which requires creditors to submit proof of their claims to the court.

The probate court judge compares the total value of claims filed by creditors to the total value of available assets in the estate. The court determines which assets are available to pay debts.

When any heir meets the department's undue hardship criteria as specified in rule 7108.3, some or all of these available assets may be exempt from adjustment or recovery by the department under these rules. Nonexempt assets are those subject to the department's claim because an heir has not met the undue hardship criteria. Creditors other than the department are not subject to these exemptions.

When the total available assets are insufficient to pay all claims, the probate court prioritizes the debts and prorates each claim according to law. Each creditor collects the resulting percentage of its claim.

If there are sufficient nonexempt assets to allow the department to collect its full percentage, it does so. If the nonexempt assets allow the department to collect only a partial amount of its share after the court's proration, it collects that amount. The department shall maintain its original claim so it can be prorated along with all other creditors claims according to law. The department notifies the court of its decision on the homestead exemption. If the department grants a homestead exemption, it shall inform the court of the maximum payment it will accept against its claim. The department determines the maximum payment it will accept by subtracting the amount of the exemption from the amount of the department's claim.

7108.3.4 Retroactive Homestead Exemptions

The undue hardship exemption applicable to homesteads shall be effective for any probate estate opened after June 30, 1999. Heirs seeking the exemption from July 1, 1999, through the effective date of this policy must submit their claim to the department's Coordination of Benefits unit in the Office of Vermont Health Access within 60 days following receipt of proper notice from the department. In the sole discretion of the commissioner, the department may make exceptions to the 60-day rule when an heir establishes undue hardship due to lack of notice, a medical need, or natural disaster. Heirs seeking an exemption from the 60-day submission requirement must sign an affidavit describing the condition that prevented them from complying with the 60-day submission requirement and submit the affidavit along with supporting documentation to the commissioner.

7108.3.5 Long-Term Care Insurance Partnership Exemption

The department will exempt assets or resources pursuant to rule 4242.2 in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified State long-term care insurance partnership policy whether or not an heir requests an exemption.

7109 Health Care Trust Fund (10/01/1995, 95-28)

In accordance with 33 VSA §1956, a Health Care Trust Fund is established in which proceeds from health care provider taxes shall be deposited. The proceeds of other taxes designated by law and donations may also be deposited in the fund.

Health care provider taxes shall be assessed upon hospitals, nursing homes and intermediate care facilities for the mentally retarded (ICF/MRs) licensed in Vermont, pursuant to 33 VSA §1953, §1954, and §1955, in an amount established by statute.

For each fiscal year in which health care provider taxes are due, the Office of Vermont Health Access (OVHA) shall notify each provider of the amount of its assessment. The notification shall include the appeals provisions set forth in 33 VSA §1958 and shall establish an assessment payment schedule for each provider.

Payment in full of each installment must be sent to the OVHA post marked no later than the date specified for each payment by the Director in the assessment notification. Late payments will be subject to a late fee assessment of eight percent or $1,000, whichever is less. The filing of a request for reconsideration, pursuant to 33 VSA §1958, does not relieve a provider from its obligation to make timely payments.

For hospital fiscal years ending after June 30, 1993, hospitals are required to identify gross inpatient revenues as a separate footnote in their audited financial statement.