Version History Table			
Date:	**Document:**	**Changes Made:**	**Impacted Pages:**
05/2025	LTC Insurance Payment Recovery Process	Newly created document	All

LTC Insurance Payment Recovery Process

Background: MLTC collects insurance payments from LTC (long term care) insurance companies for payments that are made to nursing facilities on behalf of a Medicaid eligible individual.

- The LTC Program in the Recovery Cost Avoidance unit works with insurance companies to obtain these payments.
- These reimbursements go to the Medicaid program to continue funding members of Medicaid.
- More information regarding the LTC program can be found online: https://dhhs.ne.gov/Pages/Medicaid-and-Private-Insurance.aspx

The goal of the LTC Program is to ensure that DHHS is being reimbursed for benefits that are paid on behalf of a Medicaid eligible individual when they enter an assisted living facility or a nursing home. All payments that are reimbursed by private LTC insurance companies are used to fund the Medicaid program. 471 NAC 3-005.12

This process assists the Medicaid program in ensuring accurate Medicaid funding is used and reimbursements from an LTC policy for a Medicaid eligible individual is allocated correctly.

Eligibility Worker Actions

The most important step is the identification of these policies for an individual who is in a nursing home, assisted living facility, or when a Medicaid eligible individual has passed away. When working cases, and an LTC policy is identified, the eligibility worker must gather some information regarding the policy before proceeding:

- Insurance coverage information company name, policy number, etc.
- Whether or not there is a payment being made by the LTC insurance company at the present time. If there is a payment being made- is it being made to the individual or to a facility? And the amount of the payment.
- If there is no payment being made, is it because it's within the first 100 days of the individual's stay at the facility: or
- Why is there no payment being made from the policy?

If the insurance policy is not in C1/MMIS already, it must be added by the eligibility worker prior to sending the email to the LTC Program.

- For instructions on how to enter C1/MMIS, see the C1 TPL Quick Reference Guide for additional information.

Once the eligibility worker has this information and has added the LTC policy to C1/MMIS, they must send an email to the LTC Program at DHHS.MedicaidLTCInsurance@Nebraska.gov informing them that a Medicaid eligible individual has:

- Either passed away or has entered a facility and that they have private LTC insurance. **NOTE: the eligibility worker does not need to email this mailbox if a client has LTC insurance and is not in an LTC facility.**

  The email to the LTC Program must contain the following information:

  - Individual's name and Master Case number.
  - Medicaid effective date for individual.
  - Insurance coverage information company name, policy number, etc.; and
  - Power Of Attorney (POA) or Authorized Representative: name, address, phone number.

The eligibility worker must explain to the individual/ their Authorized Representative that their LTC policy must be assigned to DHHS and let them know that paperwork will be sent to them regarding assignment of the policy.

- If the payment is made to the facility, the facility will need to forward the payment to DHHS and can work with the LTC Program through their process outlined below.
- If the payment is made to the individual, the eligibility worker will obtain the amount of the payment and enter the reimbursement as unearned income in the individual's Medicaid budget.

Throughout the course of each Medicaid case an eligibility worker may receive an electronic change request on cases from the LTC Program as outlined below. Each case is different and there will be different times or instances when the reimbursements from LTC policies may or may not need to be added or removed for an individual's Medicaid budget as unearned income. Additionally, there may be instances where a Medicaid case may be sanctioned causing a case closure for non-cooperation if assignment of benefits to the state is not completed.

LTC Program Actions

Once the LTC insurance policy has been added to C1/MMIS and the email has been sent, the LTC Program will then create a file and send the *Assignment of Benefit* letter to the POA, Authorized Representative or whomever is legally entitled to act on behalf of the Medicaid eligible individual.

NOTE: the *Assignment of Benefit* letter is not sent via NFOCUS thus the eligibility caseworker will not be able to see this in NFOCUS Correspondence.

The LTC Program will set a two-week reminder to ensure the agency has received an *Assignment of Benefit* letter for the Medicaid eligible individual.

- If the *Assignment of Benefit* letter is **not** returned by the due date:
  - A second request is sent with a new due date (two weeks out).
    - If, after the second request due date, the *Assignment of Benefit* letter is not returned:
      - The LTC Program must submit an electronic change request through iServe (https://iserve.nebraska.gov/) requesting the

eligibility worker to add the LTC reimbursements as unearned income in the individual's Medicaid budget.
    - The eligibility worker will then add the reimbursements to the individual's Medicaid budget for the next applicable month, taking into consideration adverse action.
- Later on, if the signed *Assignment of Benefit* letter is returned, the LTC Program must submit an electronic change request through iServe (https://iserve.nebraska.gov/) requesting the eligibility worker remove the LTC reimbursements from the individual's Medicaid budget for the month specified in the change request and recalculate applicable budgets.

Once the *Assignment of Benefit* letter is returned:

- The LTC Program will then mail the *Assignment of Benefit* to the LTC insurance company to ensure their files are updated.
    - Reimbursements will then be sent directly to DHHS.
    - This process can take anywhere from one to three months.
        - Each insurance company is different; some are quicker to update than others.
- The LTC Program will set a monthly reminder to review the file to ensure reimbursements are being received from the LTC insurance company.
    - If after two months the reimbursements are not sent directly to DHHS, the LTC Program will contact the insurance company to inquire if they have received the signed *Assignment of Benefit* letter or not.
        - If they have received the letter, the LTC Program must confirm whether or not the reimbursements have been sent out.
            - If yes, it must be identified where the reimbursements went.
                - If it has been determined that payment was sent to the facility, a letter is mailed to the **facility** to request the reimbursement be sent to DHHS with a due date.
                    - If the reimbursement is not received by the due date, the LTC Program must submit an electronic change request through iServe (https://iserve.nebraska.gov/) requesting the eligibility worker to add a TPL sanction onto the Medicaid eligible individual's case. This will cause the Medicaid case to close.
            - If no, it must be identified why the reimbursements have not been sent out. The LTC Program must work with the LTC insurance company to resolve this issue.
                - If it has been determined that the reimbursement was sent to the **POA or Authorized Representative,** a letter is sent to request the

reimbursement be sent to DHHS with a due date and regulation information.

- The letter advises that if the reimbursement is not received by the due date, the reimbursement will be added to the individual's Medicaid budget.

- If the POA or Authorized Representative does not respond by the due date, then a change request is sent to iServe (https://iserve.nebraska.gov/) requesting the eligibility worker to add the LTC reimbursements.
- The eligibility worker will then add the reimbursements to the individual's Medicaid budget for the next applicable month, taking into consideration adverse action.

- Once the reimbursements are switched and start being sent directly to DHHS:
  - The LTC Program must submit an electronic change request through iServe (https://iserve.nebraska.gov/) requesting the Medicaid eligibility worker to remove the LTC reimbursements as unearned income from the individual's Medicaid budget and rerun applicable budgets.

Regulations:

471 NAC 3-005.12

Long Term Care Insurance Policies: A long-term care indemnity policy is considered a health insurance policy when the policy -

1. Allows assignment of benefits; and
2. Covers medical care based on specified criteria.

Long Term Care insurance which meets these criteria is not considered income for eligibility determination.

Since nursing facility claims are included in the category of "waiver claims," Nebraska Medicaid will pay these claims at the specific per diem for the individual less any excess income/share of cost the individual is obligated to pay the provider for the monthly services. The COB Unit will seek recovery on all these policies. Since the claims have been paid, the provider shall not bill the insurer. The provider shall assist the COB Unit in obtaining reimbursement from these policies by furnishing any medical documentation the insurer requests.

A provider may choose to bill the long-term care insurance; in these situations, the provider does not bill Medicaid.

If the provider or the individual receives a payment directly from the insurer, the payment shall be sent to the COB/TPL Unit.

Whenever the Department receives any payments from long term care insurance which exceeds what Medicaid has paid toward the care of the individual, the Department shall apply the excess to any Medicaid expenditure for that Medicaid client even if the expenditure was not covered by the third party. The application of the excess TPL payment is not limited to a particular Medicaid service and can be applied to any claims for that Medicaid individual paid by Medicaid. After the excess TPL payment has been applied to all claims, any remaining amount shall be paid to the individual.

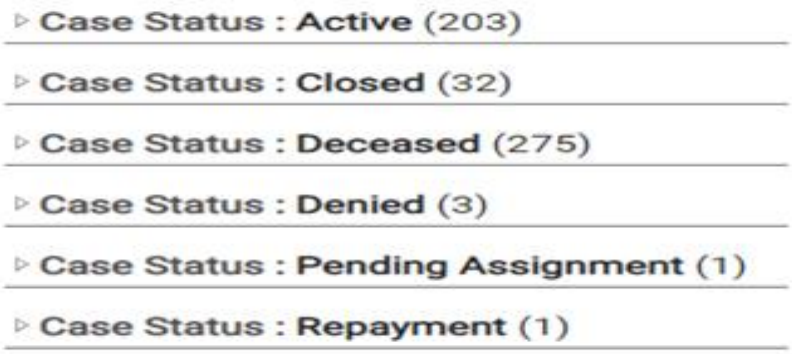
Example of an LTC Program Case List:

- **Active-** Medicaid eligible individuals who are currently active in Medicaid, are in a nursing home or Assisted Living Facility (ALF) and who have active LTC insurance listed in MMIS/C1.

- **Closed-** Medicaid eligible individuals whose Medicaid case has closed OR who have reached the maximum amount of LTC benefits that their policy will pay.

- **Deceased-** Medicaid eligible individuals who have passed away.

- **Pending Assignment-** NEW Medicaid eligible individuals who have moved into a nursing home or an Assisted Living Facility, have active private LTC insurance and the assignment of benefit letters were mailed out to the Power of Attorney, Authorized Representative or whomever is legally entitled to act on behalf of the Medicaid eligible individual—this is done by the LTC Program). The LTC Program is waiting for the signed assignment of benefit letters to be returned so that it can be sent out to the LTC insurance company letting them know that LTC reimbursements will need to be sent directly to DHHS.



Cost Avoidance Comparisons:

Additional information regarding the importance of the LTC Program and obtaining the necessary information on LTC Insurance policies—it aides in Cost Avoidance for the Medicaid Program. As shown for the following years of 2022 and 2024, for example:

- In 2022, DHHS cost avoided a total of $1,360,685.98 and recovered a total of $2,707,086.84 in reimbursements.
- This makes a combined total of $4, 067,772.82.
- In 2024, DHHS cost avoided a total of $1,138,326.66 and recovered a total of $4,062,084.58 in reimbursements.
- This makes a combined total of $5,200,411.24.

For questions or additional information please contact the DHHS.MedicaidLTCInsurance@Nebraska.gov and Angel.Lanepettiford-Hinton@Nebraska.gov mailbox.