DHCS
JENNIFER KENT
Director

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
Governor

JUL 0 2 2015

Ms. Hye Sun Lee
Acting Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare and Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Dear Ms. Lee,

The Department of Health Care Services (DHCS) is submitting the enclosed State Plan Amendment (SPA), which updates threshold limits and exclusions by the Third Party Liability and Recovery Division (TPLRD) when seeking reimbursement from a liable third party.

TPLRD has made changes to SPA 91-04 and 11-004, both of which are superseded by SPA 15-011. The new SPA adjusts the threshold for Direct Billing recoveries (recoveries directly billed on behalf of the provider by DHCS and/or the third party liability contractor to the liable third party for remittance of payment to DHCS) and adds language for Disallowance recoveries (payments recovered by DHCS from the provider, for which the provider will in turn pursue third party liability) for Commercial Insurance and Medicare. The new SPA also incorporated procedure/diagnosis codes and providers being exempted from recoveries by TPLRD.

In compliance with the new policy set forth by the American Recovery and Reinvestment Act of 2009 (ARRA), on November 19, 2010, DHCS notified Indian Health Programs and Urban Indian Organizations of SPA 15-011. On May 26, 2015, CMS approved DHCS's request to not complete the tribal/designee notification process for SPA 15-011.

Please contact Mr. Jeff Blackmon, Chief of the Third Party Liability and Recovery Division, at (916) 650-6545 or by e-mail at Jeffrey.Blackmon@dhcs.ca.gov if you have any questions.

ORIGINAL SIGNED

Enclosures

cc: Jeff Blackmon
Third Party Liability and Recovery Division
Department of Health Care Services
Other Coverage Unit, MS 4718
P.O. Box 997425
Sacramento, CA 95899-7425

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-011**

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 433.138 (g)(l)(i) and (g)(2)(i)
42 U.S.C Section 1396a(a)(25)(B)

7. FEDERAL BUDGET IMPACT: No impact.
a. FFY $
b. FFY $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.22-A, all pages
Attachment 4.22-B, all pages

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.22-A, all pages
Attachment 4.22-B, all pages

10. SUBJECT OF AMENDMENT:
Third Party Liability Medicaid Recoveries.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

ORIGINAL SIGNED

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED: JUL 0 2 2015

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

STATE PLAN UNDER TITLE OF XIX OF THE SOCIAL SECURITY ACT
State: California

Third Party Liability

(1) California obtains information for the purpose of determining the legal liability of third parties from data exchanges with the State Wage and Income Collection Agencies (SWICA), SSA wage and earnings data, State Title IV-A Agency, Commercial Insurance Carriers, State Workers Compensation files, and from the diagnosis and trauma code edits on a monthly basis.

California has a waiver for conducting a data exchange with the State Department of Motor Vehicles (DMV), as accident reports do not provide sufficient information to enable identification of a Medicaid beneficiary.

(2) The methods the California Medicaid agency uses for meeting the follow-up requirements contained in 42 CFR 433.138 (g)(l)(i)and (g)(2)(i) are as follows:

SWICA. SSA Wage and Earnings File and State Title IV-A Agency

The California Medicaid agency's Income and Eligibility Verification System (IEVS) cross matches applicant and recipient identification data with earning and income files consisting of State wage data; unemployment insurance benefit and income data; social security wage, benefits and income data; and the Internal Revenue Service and/or Franchise Tax Board unearned income data. The IEVS match is performed for all persons applying for, or receiving, Aid to Families with Dependent Children (Title IV-A) and Medi-Cal Only.

Collection of Health Insurance Information During Initial Application and Redetermination Processes for Medicaid Eligibility

Under California's Medicaid Program, eligibility determinations are performed by fifty-eight county welfare departments for individuals applying for Aid to Families with Dependent Children and the Medically needy Program, and by the Social Security Administration (SSA), for individuals who apply for Supplemental Security Income/State Supplemental Program (SSI/SSP) benefits. Eligibility for the SSI/SSP programs is determined by SSA using the following federal criteria: aged 65 or over, blind or disabled, or are a blind or disabled child; meet income and resource limits; are a U.S. citizen, or a non-citizen who has been lawfully admitted for permanent residence and meet certain special conditions, and are a U.S. resident; do not reside in a public institution; and apply for benefits from all other programs for which the applicant may qualify. As of January 1, 2014, adults without children, ages 19-64, with income below the 138 percent federal poverty level are eligible for Medicaid. Health insurance information is collected by county eligibility and SSA staff and reported to the Department for inclusion in the Medicaid Management Information System (MMIS) data base.

The collection of health insurance information is performed during the initial application and redetermination process. County eligibility and SSA staff asks the applicant whether health insurance is available. Where an indication of insurance exists, the applicant, or the parent or guardian of the applicant is given a health insurance form to complete. The county welfare

departments use the Health Insurance Questionnaire (DHS 6155) form and SSA uses the TPL information Statement (SSA-8019-U2) form to collect applicant health insurance information to report to the Department. The recipient is obligated to report to the county department any entitlement to other health care coverage at the time of application, reapplication, or redetermination; and report any change in other health care coverage no later than 10 calendar days from the date the beneficiary becomes aware of the change. The county eligibility workers are responsible for reporting private health insurance coverage for the recipients to the Department. The Department is responsible for entering the insurance information and other health coverage coding for the recipients' case records. As SSA does not have access to MEDS, the Health Insurance coding of SSI/SSP recipients' case records is performed by the Department. The Health Insurance codes are stored in MEDS to direct providers when to bill the insurance coverage. Medi-Cal recipients are also advised to use their private insurance provider when other health insurance is available. Codes are also passed to the State's fiscal intermediary via the Fiscal Intermediary Access to MEDS Eligibility (FAME) file for processing claims involving private health insurance. As federally required, the Department updates the Health Insurance System (HIS) file to be utilized for program post payment recoveries and cost avoidance within sixty (60) days of receiving the health insurance information.

Collection of Health Insurance Information by the Child Support Enforcement Program

The Child and Medical Support (IV-D) Program is administered by the Department of Child Support Services through the County District Attorney Offices, Family Support Divisions. These are known as the California Child Support Enforcement agencies or local IV-D agencies. These IV-D agencies play an important role in medical support establishment and enforcement. They are responsible for securing and enforcing court orders requiring parents to obtain and maintain health insurance coverage for dependent children. The IV-D agencies are also required to transmit relevant health insurance information to the Department when medical support is secured for the Med-Cal eligible dependent child through a court or administrative order.

The IV-D agencies report health insurance information to the Department via the electronic exchange derived by information from the Medical Insurance Form (DHS 6110). This form is designed to be completed by the Medi-Cal dependent's parents, employer of the parent, other third party providing health insurance to the parent, or the IV-D agency. The completed forms are processed by the IV-D agencies. Since Federal regulations exclude IV-D case from cost avoidance, the Department updates MEDS with the appropriate post payment recovery code and adds billing information to the HIS file. The only exception to coding for cost avoidance is if the Medi-Cal dependent's insurance coverage is reported through a Health Maintenance Organization (HMO) or a Prepaid Health Plan (PHP) without an indicator. The Department updates the HIS files within sixty (60) days of receiving the information from the Department of Child Support Services (DCSS) as federally required.

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Other Health Insurance Collection Sources

The Department also obtains beneficiary health insurance information from other sources. These sources are as follows:

Referrals:

Referrals are acknowledgments received either through electronic correspondence or telephone calls from beneficiaries, medical providers, and other government or private agencies informing the Department that a Medi-Cal beneficiary has or no longer has other health coverage. Each referral is handled by Department staff in order to update all necessary beneficiary health insurance information. Medi-Cal recipients are also advised to use their private insurance when other health insurance is present. Once complete health insurance information is obtained, it is input into the HIS file to be utilized for program post payment recoveries and cost avoidance. The Department also updates MEDS with the appropriate Other Health Coverage (OHC) indicator code.

Workers' Compensation

California's Medicaid agency receives copies of all Workers' Compensation claims from the California Department of Industrial Relations, Division of Workers Compensation. Within sixty (60) days, these claims are matched against eligibility files to identify Medi-Cal eligibles. If Medi-Cal eligibility is identified, a potential third party liability case is established and an investigation is made to determine if a recovery can be made.

(3) As stated in Section "Third Party Liability (1)", California's Medicaid agency does not obtain information from DMV.

(4) The Medicaid agency conducts edits of paid claims to identify treatment provided as a result of injury using diagnosis codes 800 through 999, with the exception of 994.6. The Department generates letters, seeking potential third party liability information, to recipients who have received $500 or more in paid services when the service listed on the claim relates to an injury diagnosis. If there is no response within sixty (60) days and paid claims exceed $750, a second letter is sent. If no response is received, a follow-up file is printed and personal contact is attempted by staff.

A quarterly report is generated indicating the number and total dollar value of all cases by individual trauma code. A second report, generated semi-annually, lists recoveries made by trauma code.

(5) In addition to the federally required data exchanges, the California Medicaid agency also conducts the following optional data exchanges:

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Private Health Insurance Carrier Data Exchanges

To identify Medi-Cal eligibles with private health coverage, the California Medicaid agency conducts data matches with a variety of private health insurance carriers and their third party administrators. Carriers are identified for data matches based on carrier size and cost benefit of the match. Data matches are also conducted by the Department's private contingency fee contractor(s). The Department or its contractor negotiates contracts and produces exchange tapes. From the resulting information, the Department updates beneficiary health insurance information on MEDS and the Department's HIS file. Through data matches, Medi-Cal beneficiaries having health coverage with the private health insurance carrier at present or any time during the past thirty-six (36) months are identified and updated in MEDS.

BENDEX

The California Medicaid agency uses the BENDEX system to identify the Social Security status and changes to a Medi-Cal beneficiary's Social Security benefits or earnings. The Department also uses the BENDEX system to identify Medicare Part A and B entitlement, option codes, effective dates, termination dates, and termination codes. The automated Buy-In system interfaces with MEDS to extract Medicare entitlement information from the BENDEX file and initiates changes in MEDS. This information is then used in the Medicare coding of the Medi-Cal card.

The Department of Social Services uses the BENDEX file for verification of AFDC recipient unearned income. This information is provided to counties through the Payment Verification System (PVS), which is a subset of IEVS. In addition, verification of wages is provided to counties from information in the Beneficiary Earnings Exchange Record (BEER) through the PVS. The BEER is part of the BENDEX.

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Third Party Liability

(1) Under state and federal law, the Medicaid agency is generally intended to be the payer of last resort for healthcare costs while third parties must assume their legal obligation to pay claims before the Medicaid agency pays for Medicaid recipients. Medi-Cal identifies potential third parties for Medicaid expenditures and utilizes the post payment recovery or cost avoidance method for claims regarding these recipients where third party liability exists. The State Medicaid agency will use the post payment recovery method for the purpose of recovering Third Party Liability when services covered under the plan are furnished to an individual whose coverage is subject to a court or administrative order by the State IV-D agency, prenatal, and preventative pediatric services. Post payment recoveries activities are initiated in accordance with the established threshold for seeking reimbursement of medical benefits from a liable third party.

The State Medicaid agency will exempt from recovery services that are listed in Supplement 1 to Attachment 4.22-B from cost avoidance and post payment recovery as the services specified are benefits provided not generally covered by commercial health insurance plans, determined not cost effective, or may result in potential privacy incidents.

The State exempts providers from recovery efforts for specific reasons based on cost effectiveness of processing claims, federal and state regulations where Medi-Cal is not designated as the payor of last resort, and bankruptcy. The providers being excluded are provided in Supplement 2 to Attachment 4.22-B.

(2) The threshold amounts used in determining whether to seek reimbursement from a liable third party are as follows:

a) Payments for care to eligibles with private health insurance are billed directly when $0.01 Electronic Billing and/or $10 Paper RX and/or $25 Paper Medical in accumulated health care services have been paid by Medi-Cal. A lower threshold is recovered when determined to be cost effective. The time limit for pursuing recoveries of Third Party Liability concerning commercial insurance is three (3) years from the original date of service.

b) Payments for care to eligibles with private health insurance are disallowed (Commerical Insurance, Medicare Institutional and Medicare Professional) monthly when $100 in accumulated health care services have been paid by Medi-Cal. A lower threshold is recovered when determined to be cost effective. The time limit for filing all Medicare fee-for-service claims is twelve 12 months, or one (1) calendar year from the date services were provided. Exceptions to the one (1) calendar year time limit are: (1) retroactive Medicare entitlement to or before the date of service of the services provided; (2) retroactive Medicare entitlement where a State Medicaid

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Agency recoups money from a provider six (6) months or more after the date of service of the services provided.

c) Potential Casualty Insurance and Workers' Compensation cases are established when Medi-Cal payment of $2,000 or more have been made. Potential Casualty Insurance and Workers' Compensation cases may be established when Medi-Cal payments of less than $2,000 have been made when the amount the State expects to recover would be greater than the cost of recovery.

d) When unsolicited money of any value is received, it is retained, researched to identify why it was received and credited to the proper account or returned to sender.

e) Estate Recovery claims are filed in the probate or distribution of assets of deceased Med-Cal beneficiaries when the health care services paid by the State are $750 or more. Estate Recovery claim may be filed in the probate distribution of assets of deceased Medi-Cal beneficiaries when health care services paid by the State are less than $750 when the amount the State expects to recover would be greater than the cost of recovery.

(3) The dollar amount used by the State Medicaid Agency for accumulating health care services payments to determine whether to bill a particular third party, are defined in (2) above.

(4) For third-party recoveries, the Department shall comply with 42 U.S.C. Section 1396a(a)(25)(B) and use the following factors and guidelines in determining whether or to what extent to pursue recovery, after deduction of the Department's share of attorney's fees and costs, from a liable party.

a) Ascertain the amount of Medicaid expenditures related to the injury and the amount of the potential gross settlement, judgment, and/or award.

b) Determine whether the full Medicaid lien, plus attorney's fees and costs, is likely to exhaust or exceed the settlement, judgment, and/or award.

c) If the Medicaid lien, plus attorney's fees and costs, exhausts or exceeds the settlement, judgment, and/or award, and if the Department:

1) Is informed that the Medicaid recipient will not pursue the claim; or has made reasonable efforts to ascertain the recipient's intention regarding the claim, but could not obtain a response; and

2) Finds it cost prohibitive to investigate and prosecute the claim to establish liability if the claim were to be tendered to the Department, then the Department shall follow the procedures stated in d).

d) The Department shall consider cost-effectiveness to the State in determining the estimated net recovery amount to be pursued, based on the likelihood of collections. In determining the estimated net recovery amount, the following factors shall be considered:

1) Settlement as may be affected by insurance coverage, policy limits, or other factors relating to the liable party;

2) The attorney's fees and litigation costs paid for by the Medicaid recipient;

3) Factual and legal issues of liability as may exist between the Medicaid recipient and third party;

4) Problems of proof faced in obtaining the settlement, judgment, and/or award;

5) The estimated attorney's fees and costs required for the Department to pursue the claim;

6) The amount of the settlement, judgment, and/or award allocated to, or expected to be allocated to, medical expenses or medical care; and

7) The extensive administrative burden that would be placed on the Department to pursue claims.

e) To ensure the highest potential recovery, the Department will first consider the above factors and then, on a case-by-case basis, determine if a recovery of a lesser amount is still cost-effective.

f) In the event the Department's lien exceeds the beneficiary's recovery after deducting, from the settlement, judgment, or award, attorney's fees and litigation costs paid for by the beneficiary, the Department will credit CMS with its full federal share regardless whether the Department's lien was settled under state law which prohibits the Department from recovering more than the beneficiary recovers.

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STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.