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

Jennifer Kent
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

12/21/2017

Ms. Henrietta Sam-Louie
Associate Regional IX Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Dear Ms. Sam-Louie:

The Department of Health Care Services (DHCS) submits State Plan Amendment (SPA) 17-042 for your review and approval. SPA 17-042 proposes to add a fixed percentage recovery option for Medi-Cal members with non workers' compensation injury-related third party settlements totaling $25,000 or less. Medi-Cal members will have the option to pay 25 percent of their gross settlement to satisfy their Medi-Cal debt, rather than having DHCS calculate a lien based on their injury-related services. This is similar to a recovery option that Medicare's Secondary Payer Recovery Program implemented in 2011.

Under federal regulations, states may implement recovery methods to improve cost-effectiveness.[1] Currently, the cost of recovery of certain personal injury (PI) cases outweighs the recovery amount. The fixed percentage option would address this problem by expediting the closure of many of these cases, resulting in administrative savings.

For PI cases generally, DHCS expects that this option will expedite approximately 25 percent of cases, as eligible Medi-Cal members could choose to pay a fixed amount of their gross settlement rather than wait an average of six to nine months for DHCS to receive payment data and calculate a lien. This is expected to result in an increase to the state's net recovery and the state's federal financial participation reimbursement. In addition to allowing eligible Medi-Cal members to receive settlements more quickly, the fixed percentage option would also enable DHCS to support growing caseloads due to the Affordable Care Act's expansion population.

[1] 42 C.F.R. Section 433.139(e).

After evaluating federal notice requirements, DHCS has determined that this SPA does not require a Public Notice. On November 17, 2017, Centers for Medicare & Medicaid informed DHCS that a tribal notice was not required for this SPA.
The proposed effective date for SPA 17-042 is October 1, 2017.

If you have any questions or need additional information, please contact Margaret Hoffeditz, Chief, Third Party Liability and Recovery Division, at (916) 650-0582, or by email at Margaret.Hoffeditz@dhcs.ca.gov.

ORIGINAL SIGNED

Health Care Programs
State Medicaid Director

Enclosures

cc: Erika Sperbeck
Chief Deputy Director
Policy and Program Support
Department of Health Care Services
Erika.Sperbeck@dhcs.ca.gov

Margaret Hoffeditz, Chief
Third Party Liability and Recovery Division
Department of Health Care Services
Margaret.Hoffeditz@dhcs.ca.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 1 7 — 0 4 2

2. STATE: CA

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 1, 2017

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 Section 433.139(e)

7. FEDERAL BUDGET IMPACT
a. FFY 2017-2018 $ 605
b. FFY 2018-2019 $ 1,816

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.22-B pages 1-4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.22-B pages 1-4

10. SUBJECT OF AMENDMENT
Fixed Percentage Recovery Option

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

ORIGINAL SIGNED

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
12/21/2017

16. RETURN TO
1501 Capitol Avenue, MS 0000
Sacramento, CA 95814

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

Instructions on Back

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. The State Medicaid agency 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 services from recovery determined by the State Medicaid agency based on cost effectiveness, good cause, or privacy concerns for services rendered for mental (in specific circumstances), substance abuse treatment, sexual, and reproductive health.

(2) The State Medicaid agency exempts providers from recovery efforts for specific reasons based on the cost effectiveness. 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 other health coverage (Tricare or non-Medicaid plans which do include employer-sponsored plans) are billed directly when $0.01 electronic billing, $10 Paper prescription billing, and $25 paper medical billing in accumulated health care services have been paid by the Medicaid agency. A lower amount is recoverable when determined by the Medicaid agency to be cost effective. The time limit for pursuing recoveries of Third Party Liability concerning Tricare is one (1) year from the original date of service. The time limit for filing all Medicare claims is generally one year from the date of service, subject to Federal law and regulations which may alter recovery time limits. All other health coverage is three (3) calendar years from the original date of service.

b) Payments for care to eligibles with other health coverage (Tricare and non-Medicaid health insurance including employer sponsored plans, Medicare

Institutional and Medicare Professional) are disallowed monthly when $100 in accumulated health care services have been paid by the State Medicaid agency. A lower amount is recoverable when determined by the State Medicaid agency to be cost effective. The time limit for filing all Tricare fee-for-service claims is one (1) calendar year from the date services were provided. The time limit for filing all Medicare claims is generally one year from the date of service, subject to Federal law and regulations which may alter recovery time limits. All other health coverage is three (3) calendar years from the original date of service.

c) Cases are categorized by injury diagnosis code(s), type of insurance claim, insurance carrier(s), or presence of other health coverage.
   i. Fixed Percentage Option: For injury-related cases not involving worker's compensation that have a total settlement value of $25,000 or less from all related actions or claims, the Department may accept 25 percent of the total gross settlement value as payment in full to satisfy the Department's recovery claim. The Department must receive a written request for the fixed percentage recovery option prior to or along with the documentation for the Settlement Release, and must not have received a prior request to perfect a recovery lien. The Department will approve or deny all requests within 30 days of the date of receipt.
   ii. Low Yield Injuries: Case categories with a historical claim average of $2,000 or less may not be pursued.
   iii. Low Dollar Cases: For all other cases, if the total amount of paid injury-related claims is $2,000 or less through the date of settlement or final injury-related treatment, whichever occurred earlier, the Department will send a lien to request payment; however, the Department will not pursue continued collection or litigation.

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.

(3) The dollar amount or time frame, 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. Where the action or claim is brought by the beneficiary alone, or where the beneficiary incurs a personal liability to pay attorney's fees, the Department reduces its lien by 25 percent. If the casualty insurance or workers' compensation carrier directly reimburses the attorneys' fees so the beneficiary incurs no cost or if there is no attorney, this reduction does not apply.

a) Ascertain the amount of Medicaid expenditures related to the injury and the amount of the potential gross settlement, judgment, and/or award. The Department is limited to the portion of the settlement or award that designated for medical expenses.

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.

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) Whether a timely written request for the fixed percentage recovery option has been submitted to, and approved by, the Department;

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

8) 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.

(5) The State Medicaid Agency shall ensure that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

(6) The State Medicaid has and shall maintain written cooperative agreements for the enforcement of rights to and the collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the State IV-D agency to meet the requirements of 42 CFR 433.152 (b).

(7) The State Medicaid agency assures that the State has in effect laws relating to Medical child support under section 1908A of the act (1902(a)(60) of the SSA).