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

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 uses cost avoidance for prenatal services, including labor, delivery, and postpartum care services. 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 in accordance with the Social Security Act section 1902(a)(25)(F), for those in rural counties where a geographical barrier exists, and preventative pediatric services in accordance with the Social Security Act section 1902(a)(25)(E). Medical child support services will be paid by the State Medicaid agency within 30 days as it has determined it is cost effective and necessary to ensure access to care. Preventative pediatric services will be paid for without regard to the liability of a third party payment. Post-payment recovery activities are initiated in accordance with the established threshold for seeking reimbursement of medical benefits from a liable third party.

If a response from a carrier is not received within 90 days of the provider's billing date, providers may bill the State Medicaid agency for any Medicaid service. A copy of the completed and dated insurance claim form must accompany the claim.

The State Medicaid agency will exempt services from cost avoidance or recovery determined by the State Medicaid agency based on cost effectiveness, good cause (safety concerns for at-risk children), individuals in foster care or adoption assistance aid codes, 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. For Medicare Part A there is a threshold of $25 per claim, and $100 per provider. 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. Case categories with a historical claim average of $2,000 or less may not be pursued. 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, judgment, and/or award that is designated for medical expenses. If undesignated, the allocation for medical expenses shall be deemed to be no more than 50 percent of the settlement, judgment, and/or award after deducting attorney's fees and litigation costs. The Department shall reimburse CMS based on the recovered amount and the applicable Federal Financial Participation (FFP) rate.

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

c) 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.

d) 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.

e) Barring cases resolved for cost-effectiveness, if the medical allocation of a designated settlement, judgment, and/or award, after deducting attorney's fees and litigation costs, exceeds 50 percent, the Department will credit CMS with its full federal share based on the medical allocation.

(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).

(8) State laws are in effect that require third parties to comply with the provisions of 1902(a)(25)(I) of the Social Security Act in the Consolidated Appropriations Act of 2022. (CAA), California Senate Bill 1511 (Committee on Health, Chapter 492, Statutes of 2024) modifying section 10022 of California Welfare and Institutions Code requires that if a responsible third party requires prior authorization for an item or service furnished to a Medicaid eligible individual, the responsible third party must accept the authorization provided by the State that the item or service is covered under the State Plan (or waiver of such Plan) for such individual, as if such authorization was made by the third party for such item or service. As further provided by the CAA, State law also requires third party payers to respond to a State inquiry within 60 days of receiving the inquiry.