

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 1, 2016

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 15-011. This SPA was submitted to my office on July 2, 2015 and updates the Coordination of Benefits/Third Party Liability (COB/TPL) cost-effectiveness threshold amounts and makes adjustments to the trauma code editing protocols.

The effective date of this SPA is July 1, 2015. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Attachment 4.22-A, pages 1-4
- Attachment 4.22-B, pages 1-3
- Supplement 1 to Attachment 4.22-A, page 1

If you have any questions, please contact Cheryl Young by phone at (415) 744-3598 or by email at Cheryl.Young@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louie
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Brian Fitzgerald, California Department of Health Care Services
Geoffrey Blackmon, California Department of Health Care Services
Nathaniel Emery, California Department of Health Care Services

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 15-011	2. STATE CA
FOR: HEALTH CARE FINANCING ADMINISTRATION		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): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(25) and Section 1912(a) of the Social Security Act; 42 CFR 433.138, 42 CFR 433.139 and 42 CFR 433.151		7. FEDERAL BUDGET IMPACT: No impact. a. FFY 15 \$ 0 b. FFY 16 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.22-A, pages 1-4 Attachment 4.22-B, pages 1-3 Supplement 1 to Attachment 4.22-A, page 1		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.22-A, pages 1-5 Attachment 4.22-B, pages 1-2 Supplement 1 to Attachment 4.22-A, page 1	
10. SUBJECT OF AMENDMENT: Third Party Liability Medicaid Recoveries.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The Governor's Office does not wish to review the State Plan Amendment.			
15. DATE SUBMITTED: <u>July 2, 2015</u>			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: <u>July 2, 2015</u>		18. DATE APPROVED:	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <u>July 1, 2015</u>		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Henrietta Sam Louie		22. TITLE: Acting Associate Regional Administrator, Division of Medicaid & Children's Health Operations	
23. REMARKS: Boxes 6, 7, 8 and 9 added by DHCS per CMS request as part of response to Request for Additional Information (RAI) dated 11/6/15.			

Henrietta Sam Louie

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, State Title IV-D Agency, Commercial Insurance Carriers, Referrals, Health Insurance Premium Payment TPL Reviews, 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)(1)(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

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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 other health coverage (Tricare and non-Medicaid plans) of 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 the Medi-Cal Eligibility Data System (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 State Title IV-D Agency

The Child Support Enforcement (IV-D) Program is administered by the Department of Child Support Services through the County Child Support Agency Offices. 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 Med-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 another health coverage carrier 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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Private Health Insurance Carrier Data Exchanges

To identify Medi-Cal eligibles with other health coverage, the California Medicaid agency conducts data matches with a variety of other health coverage 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 other health coverage 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.

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 other health coverage (Tricare and non-Medicaid plans) when other health benefits or insurance is available. 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.

Health Insurance Premium Payment TPL Review

When an individual inquires about participation in the Health Insurance Premium Payment (HIPP) Program, Department staff request the individual's Social Security Number in order to review MEDS for share of cost, Other Health Coverage (OHC) Information, Medicare

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entitlement and Medi-Cal eligibility. If MEDS indicates no OHC code, the individual is asked if he/she has health insurance coverage. If the individual responds in the affirmative, he/she is asked to provide specific health insurance information (i.e., carrier name, carrier address, policy number, and scope of coverage). Once complete information is obtained, the Department updates MEDS with the appropriate OHC indicator and the Health Insurance (HIS) file.

Workers' Compensation

California's Medicaid agency receives copies of all Workers' Compensation Appeals claims. Within sixty 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. In addition, copies of applications for adjudication are sent to the Department of Social Services (DSS). In turn, DSS sends these copies to the appropriate local IV-D agency District Attorney (DA) office. If the absent parent has employer related health insurance coverage available, the county DA office provides follow-up service to identify whether the appeal can be linked to an active Medi-Cal dependent IV-D case. If the DA discovers employer coverage, the DA requires the absent parent, through a court or administrative order, to provide health insurance and to complete medical insurance form DHS 6110. The completed DHS 6110 forms are sent by the DA's office of the Department.

- (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 trauma diagnosis codes from the International Classification of Disease in effect on the date of service. The Department generates letters, seeking potential third party liability information, when the service listed on the claim relates to an injury diagnosis and it is cost-effective to do so.

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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. 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

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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 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.

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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.
- (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).

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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.

TN No. 15-011

Supersedes

TN No. 08-004

Approval Date: February 1, 2016

Effective Date: July 1, 2015