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State/Territory Name: California

State Plan Amendment (SPA) #: 20-0037

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

November 6, 2020

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

Dear Ms. Cooper:

Enclosed is an approved copy of California State Plan Amendment (SPA) 20-0037, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 22, 2020. This SPA updates the third-party liability section of the state plan to use standard coordination of benefits cost avoidance when processing claims for prenatal services. These changes align with Section 1902(a)(25)(E) of the Social Security Act as amended by the Bipartisan Budget Act of 2018.

The effective date of this SPA is October 1, 2020 as requested. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Attachment 4.22-B, pages 1-4

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

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosure

cc: Erika Sperbeck, Department of Health Care Services (DHCS)
Bill Otterbeck, DHCS
Margaret Hoffeditz, DHCS
Aaron Toyama, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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: 20 — 0037

2. STATE: California

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act

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

4. PROPOSED EFFECTIVE DATE: October 1, 2020

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: Section 1902(a)(25)(E)

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $ 1 (in thousands)
b. FFY 2022 $ 1 (in thousands)

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 1-3

10. SUBJECT OF AMENDMENT

Third party liability updates in accordance with the Bipartisan Budget Act of 2018.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME: Jacey Cooper

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: September 22, 2020

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 22, 2020

18. DATE APPROVED: November 6, 2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]
Digitally signed by James G. Scott -S
Date: 2020.11.06 15:47:58 -06'00'

21. TYPED NAME: James G. Scott

22. TITLE: Director, Division of Program Operations

23. REMARKS

For Box 11 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

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 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), and preventative pediatric services in accordance with the Social Security Act section 1902(a)(25)(E). Post-payment recovery 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. 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.

   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).