MEDICAID OPERATIONS MANUAL
TRANSMITTAL LETTER

July 30, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF OPERATIONS /Tammy Moffitt/

SUBJECT: MEDICAID OPERATIONS MANUAL CHANGES
CHAPTER 800 – COST SAVINGS PROGRAM

BACKGROUND AND EXPLANATION

The Division of Health Care Financing and Policy (DHCFP) proposes to add the definition of Permanent Institutional Status. This change is being made to clarify this status.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: None.

Financial Impact on Local Government: None.

These changes are effective July 31, 2019.

MATERIAL TRANSMITTED		MATERIAL SUPERSEDED
MTL 13/19 MOM Ch 800 – Cost Savings Program		MTL 02/19 MOM Ch 800 – Cost Savings Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
802.3	**PERMANENT INSTITUTIONAL STATUS**	New definition added.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID OPERATIONS MANUAL
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MEDICAID ESTATE RECOVERY (MER) PROGRAM

800 INTRODUCTION

Cost Savings Programs are considered measures or actions that lower current spending such as recouping paid funds from liable third party/parties. Medicaid Estate Recovery (MER) and Subrogation – Third Party Liability (TPL) and probate duties are considered to be measurable actions to cost savings.

800.1 Federal and state law mandates state operation of the MER program whereby correctly paid Medicaid benefits are recoverable from the estate of a deceased Medicaid recipient. Recovery is accomplished only after the death of a recipient and at a time when there is no surviving spouse, children under the age of 21, or blind or disabled children of any age, as defined by Section 1614 of the Social Security Act (SSA).

Regulations of the MER program affects individuals who received Medicaid benefits on or after October 1, 1993. Collections will be pursued against the estate of the recipient up to the amount of Medicaid benefits correctly paid or up to the determined value of the recipient's estate whichever is less.

MER staff are located at the Division of Health Care Financing and Policy (DHCFP), 1100 E. William St. Suite 109, Carson City Nevada 89701; Phone (775) 687-8414 and Fax (775) 684-3720; mer@dhcfp.nv.gov.

800.2 In certain trauma situations, there may be a source of medical payments other than regular health insurance. This source could be through automobile insurance, homeowner's insurance, liability insurance, etc. A provider may elect to bill or file a lien against those sources, or Medicaid may be billed.

Under 31 Code of Federal Regulations (CFR) 50.104, an insurer shall not waive its rights of subrogation under its property and casualty insurance policy concerning any losses the payment of which the insurer intends to include in its insurer deductible or the aggregate insured losses for purposes of calculating the Federal share of compensation of its insured losses. As a representation of theory and interpretation behind insurance subrogation, Nevada Medicaid will allow providers who accept(ed) a Medicaid payment for services directly related to injuries or accidents to subsequently return that payment to Medicaid in order to seek reimbursement directly from a liable third party.

Subrogation casualty case recoupment is the collaborative work between the DHCFP, States Fiscal Agent and TPL vendor. Managed Care Organizations (MCOs) and the Dental Benefit Administrator are required to pursue their enrollees subrogation cases and to provide reports outlined in the Medicaid Service Manual (MSM) and their contract requirements.

801 AUTHORITY

Authority for operating the MER program is published in Section 1917 of the SSA and Nevada Revised Statutes (NRS) 422.054; 422.29301; 42229302; and et.seq.

Sections 1902(a)(25), 1912 and 1917 allows States the ability to recover the cost from the full amount of a liability settlement, instead of a portion of the settlement.

31 CFR 50.105 Subrogation

42 CFR, Part 433, Subpart D, 42 CFR 433.145, 433.146(c) and 433.154

State Medicaid Manual (SMM) 3905.2 and 3908

NRS 422.293 Subrogation, Rights and Responsibilities

Nevada Medicaid State Plan Section 4.22; Third Party Liability, Attachment 4.22-B

Worker's compensation insurance coverage is required for all providers pursuant to NRS Chapters 616A through 616B.

802 DEFINITIONS

802.1 AFFECTED INDIVIDUALS

MER actions are imposed against Medicaid recipients who are:

- Fifty-five years of age or older when they receive Medicaid assistance; or
- An inpatient in a nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID) or other medical institution, where they are required to spend for costs of medical care all but a minimal amount of income which is permitted for the recipient's personal needs.

802.2 ESTATE

For the purposes of MER, "Estate" means assets included in the estate of the deceased recipient of assistance to the medically indigent and any other assets in or to which the recipient had an interest or legal title immediately before or at the time of death, to the extent of that interest or title (NRS 422.054). The term includes assets passing by reason of joint tenancy, reserved life estate, survivorship, trust, annuity, homestead or other arrangement.

802.3 PERMANENT INSTITUTIONAL STATUS

1. A Medicaid recipient with Permanent Institutional Status is defined by the Department in accordance with 42 United States Code (USC) 1396p(a)(1)(B) as an individual who is an inpatient in a nursing facility, intermediate care facility for individuals with intellectual disabilities or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for the costs of medical care all but the minimal amount of his/her income required for personal needs, and with respect to whom the State determines, subject to notice and opportunity for a hearing (in accordance with procedures established by the State), that he/she cannot reasonably be expected to be discharged from the medical institution and to return home.

2. A recipient cannot reasonably be expected to be discharged from the medical institution and to return home if:

   a. the individual declares that he or she does not intend to return home; or

   b. the individual has continually resided in a nursing facility, intermediate care facility for individuals with intellectual disabilities or other medical institution for 90 or more consecutive days; or

c. the individual dies in a nursing facility, intermediate care facility for individuals with intellectual disabilities or other medical institution prior to 90 days residence.

3. "Return home" is defined as the recipient leaving the nursing or medical facility and residing in a residential property for a continuous period of at least 90 days without being readmitted as an inpatient to a nursing or medical facility.

4. Upon determination by the Department that a recipient has Permanent Institutional Status, the Department must provide to the recipient or his or her legal guardian or representative, each executor, administrator or trustee of the recipient's estate, and/or any heirs of the recipient known to the Department written notice of its decision and the right to request a hearing within 90 days.

5. Any person who objects to the Department's determination and alleges that there is a reasonable expectation of discharge from the facility and a return home, has the burden of demonstrating the reasonable expectation and/or return home. The reasonable expectation must be established based upon medical evidence and medical opinion. In addition, a declaration by the recipient or a recipient's representative that the recipient intends to be discharged from the facility and to return home is not alone sufficient to establish that there is a reasonable expectation of discharge from the facility and return home.

802.4 PROBATE

The legal process by which the assets of a decedent are properly distributed (if he or she made a will) to the beneficiaries or heirs through an executor named in the will, or (if he or she died without a will) according to the local law by a court-appointed administrator. The court's objective is to ensure that the deceased's debts, taxes and other valid claims are paid out of his or her estate (probate assets) before any distribution is made to the estate's beneficiaries, in accordance with the will (if it exists) or on the orders of the court (if it doesn't exist).

802.5 DEPUTY ATTORNEY GENERAL (DAG)

The DHCFP works directly with the Deputy Attorney General(s) (DAG) for complex case decisions and guidance.

802.6 CASUALTY LIEN REDUCTION

For the purpose of TPL, casualty is the result of an accident, mishap or disaster. The result of casualty may lead to entering a lien; a right to keep possession of property or a form of cash settlement, belonging to another person until a debt owed is negotiated, paid at the level of cost accrued or discharged.

802.7 SUBROGATION

Subrogation refers to an insurer's right to recover the amount it has paid for a loss from the party that caused the loss.

803 MER POLICY

803.1 NOTIFICATION TO AFFECTED INDIVIDUALS

Full disclosure of the MER program operation is made during the application process. Statements regarding MER are included on the eligibility application and applicants (or their representatives) are given Form 6160-AF, "Medicaid Estate Recovery Notification of Program Operation." Staff MUST attempt to secure the acknowledgment (via signature) of information provided on Form 6160-AF. However, the applicant's (or their representative's) failure to sign the form does not preclude the pursuit of correctly paid benefits.

Form 6160-AF, Medicaid Estate Recovery Notification of Program Operation, must be given to all applicants for Medicaid assistance at the time of application for services and redetermination. Provide the applicant the form in English or Spanish, whichever is appropriate.

One copy of the form will be given to the applicant and one dated copy will be filed in the Medicaid eligibility case file.

803.2 REFERRAL CASES TO MER UNIT

When a MER affected recipient is no longer Medicaid eligible due to death, the eligibility worker MUST forward their case file to MER within three working days after the closure of the Medicaid case file resulting from the death of the Medicaid recipient.

Eligibility staff will request in writing the return of the case file, if necessary. The written request must include the name and Social Security Number of the client; the date of the request; the eligibility staff member requesting the file and the district office where the file should be sent. This request may be faxed or forwarded to Attention: MER, utilizing interoffice mail. MER staff will provide the case file within three working days.

Case files for Medicaid applicants who have been denied Medicaid eligibility and who do not have a history of prior approval should not be forwarded to the MER unit.

803.3 INITIATION OF MER ACTIVITIES

Upon receipt of the closed Medicaid eligibility case file, MER personnel will establish a MER recovery case. MER staff will validate the recipient's reported resource information.

803.4 NOTIFICATION OF RECIPIENT'S HEIRS

When MER staff receives notification of an affected Medicaid recipient's death, they will provide their known heirs with a written notice which:

A. Advises of the State's intent to recover the value of Medicaid benefits paid on the recipient's behalf from the recipient's estate; and

B. Provides information addressing Medicaid payments made on behalf of the recipient; and

C. Includes a statement advising the amount the MER claim may increase if there are additional Medicaid claims which have not yet been processed.

All MER notices will include a statement advising the recipient's heirs of the MER hardship waiver provisions.

803.5 IDENTIFICATION OF MER COLLECTIBLES

After the reported death of an affected recipient, MER personnel will review the recipient's estate to determine an estimated dollar value. Assets information will be recorded in the recipient's MER file and will serve as the maximum amount recoverable under the MER program.

MER actions will be pursued against the estate of the recipient up to the amount of Medicaid benefits correctly paid or up to the determined value of the recipient's estate whichever is less.

803.6 INITIATING MER COLLECTIONS

After the recipient's death, MER personnel will immediately pursue adjustments or recovery of any Medicaid assistance correctly paid on behalf of the recipient from the recipient's estate or upon the sale of the recipient's real property.

Any adjustment or recovery against a recipient may be made only after the death of the recipient's surviving spouse, if any, and only at a time when:

A. The recipient has no surviving child who is under 21 years of age; or

B. The recipient has no surviving child who is blind or disabled, of any age, as defined by Section 1614 of the SSA.

803.7 RECOVERY AGAINST AN ESTATE

After the death of an affected recipient, and in accordance with NRS, MER personnel will immediately file a claim against the estate of the recipient for the full value of Medicaid benefits paid on behalf of the recipient. Once MER staff has requested the deceased recipient's case file, eligibility staff will forward the case file to MER within three working days.

Claims will be filed with:

A. The court having jurisdiction over the recipient's estate pursuant to NRS 147.040; or

B. Any individual or entity empowered with the legal ability to control, liquidate or transfer any part of the recipient's estate.

803.8 IMPOSITION OF LIENS

Liens may be imposed to protect recovery of estate assets for correctly paid Medicaid benefits when permitted by federal and state law. The purpose of the lien is to facilitate recovery of Medicaid benefits when it is appropriate and allowable by law to do so. It is not intended to impair the ability of the surviving spouse or another qualified individual to sell or refinance the property if so desired, nor is it intended to force the premature sale of the property. Action is never taken on liens until or unless all exemptions allowed by federal law no longer apply.

The State's lien would only be against the interest in that property the Medicaid recipient had at the time of death or the Medicaid claim, whichever is less.

Federal law prohibits recovery on a lien when there is a surviving spouse, children under the age of 21 or blind and/or disabled children of any age. The State must release a lien if a surviving spouse, a child under age 21 or blind or disabled child of any age, as defined by Section 1614 of the SSA, or a legal representative desire to engage in a bona fide sale or financial transaction involving the property. If the property is refinanced, the State has the option of re-petitioning for the placement of the lien.

In the event of incorrectly paid benefits, a lien may be imposed on both real and personal property with authority of a court judgment without regard to circumstances.

803.9 POSTPONING/TERMINATING MER ACTIONS

If, after the reported death of the recipient, immediate MER action is prohibited because of exception conditions, MER personnel postpone MER action until all exception conditions are no longer present. Termination of MER action will occur when all real and personal property included as part of the recipient's estate is no longer accessible.

803.10 RECEIPTING/POSTING MER COLLECTIONS

All MER collections will be received by MER personnel located at the DHCFP.

Payment may be made by check, money order or wire transfer, made payable to Medicaid Estate Recovery, Department of Health and Human Services, or Nevada State Treasurer. MER does not accept cash or credit card as a form of payment

Do not state verbally or in writing that this payment releases the heir from MER action.

803.11 EXCLUSION FROM RECOVERY

A. The following income, resources and property are exempt from MER:

1. Certain income and resources of American Indians and Alaska Natives. Income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;

2. Ownership interest in trust or non-trust property, including real property and improvements:

a. Located on a reservation (any federally recognized Indian tribal reservation, Pueblo or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotment) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or

b. For any federally-recognized tribe not described in (a) located within the most recent boundaries of a prior federal reservation.

c. Protection of non-trust property described above is limited to circumstances when it passes from an Indian (as defined in Section 4 of the Indian Health Care Improvement Act) to one or more relatives (by blood, adoption or marriage) including Indians not enrolled as members of a tribe and non-Indians, such as spouses and stepchildren; that their culture would nevertheless protect as family members, to a tribe or tribal organization; and/or to one or more Indians.

3. Income left as a remainder in an estate derived from property protected in (b) above that was either collected by an Indian or by a tribe or tribal organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property;

4. Ownership interests left as a remainder in an estate in rents, leases, royalties or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish and shellfish) resulting from the exercise of federally-protected rights, and income either collected by an Indian or by a tribe or tribal organization and distributed to Indian(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and

5. Ownership interest in or usage rights to items not covered by 1 - 4 above that have unique religious, spiritual, traditional and/or cultural significance or rights that support subsistence or a traditional and/or cultural significance, or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom;

6. Government reparation payments to special populations.

B. Income, resources and property of American Indians and Alaska Natives, which are not exempt from Medicaid estate recovery:

1. Ownership interests in assets and property, both real and personal, that are not described in the above items.

2. Any income and assets left as a remainder in an estate that does not derive from protected property or sources listed above.

803.12 HARDSHIP WAIVER

At the time recovery is initiated, the MER recovery specialist will discuss hardship waivers, compromises or adjustments to the State's claim. Hardship requests will be submitted to the administrator or their appointed representative of the DHCFP for review. The denial of a hardship waiver may be appealed through an administrative hearing.

There is no hardship waiver provided at the time of lien placement against the real property of a deceased Medicaid recipient. The equity interest of the heir will be considered to determine the percentage of the deceased recipient's interest in the property. Lien placement is utilized to delay recovery until such time an exemption to recovery does not exist, or in the case of a hardship, until such time as the hardship no longer exists. The State's lien would be the Medicaid benefits paid on behalf of the recipient or the percentage of interest of the deceased recipient at the time of sale, whichever is less.

803.13 HARDSHIP WAIVER CRITERIA

The State will waive enforcement of any estate recovery claim when the requesting party is able to show, through convincing evidence, the State's pursuit of estate recovery subjects them to undue hardship. A claim for emotional hardship is not considered sufficient to warrant waiver approval. No waiver will be granted if the Division finds the undue hardship was created by estate planning methods by which the waiver applicant or deceased client divested, transferred or otherwise encumbered assets in whole or part, to avoid estate recovery. In determining whether undue hardship exists, the following criteria will be used:

A. The asset to be recovered is the sole income-producing asset of the applicant; or

B. The recovery of the assets would result in the applicant becoming eligible for governmental public assistance based on need and/or medical assistance programs; or

C. A doctor's written verification of a medical condition that compromises the applicant's ability to repay the Medicaid claim.

If an undue hardship waiver is requested and the State determines that none of the above conditions apply, full payment of the claim may be ordered, recovery may be temporarily waived, compromised or modified. The following factors shall be considered individually or in combination when making a decision to temporarily waive, modify or compromise estate recovery:

D. The gross annual income, property and other assets of the applicant and their immediate family;

E. The type and level of care provided by the applicant (caregiver) to the decedent and the extent to which the care delayed or prevented the institutionalization of the decedent. The State uses the following process for determining if the applicants will be considered as caregivers when through clear evidence they substantiate;

1. Maintained residency in the Medicaid recipient's home for at least two years immediately preceding the recipient's death or admission into a nursing facility, ICF/IID or other medical institutions; and

2. Provided care for Medicaid recipient which meets or exceeds published state standard established for Intermediate Care Level (ICL 1), which includes as necessary, assisting the individual with ambulatory needs, feeding, grooming, personal hygiene, oral hygiene, nail care, bathing, toilet activities, skin care and medical needs.

3. The applicant continuously resided with the decedent for two years or more immediately prior to the decedent's death and continues to reside in the decedent's residence and the prior occupancy permitted the decedent to reside at home rather than in an institution;

4. The estimated value of the real or personal property at issue. If the cost of recovering the asset(s) of the deceased Medicaid recipient is more than the value of the asset(s), it would not be cost-effective to recover, and/or

5. The financial impact of recovery against immediate family members of the applicant.

6. Applicants who seek a recovery delay (i.e., temporary waiver) will be given the opportunity to provide written details or complete an "Application for a Hardship

Waiver Regarding Recovery of Correctly Paid Medicaid Benefits" form within 30 days of notification of the Division's intent to recover.

F. The following collection methods may be used when recovery is temporarily waived, compromised or modified:

1. Reduction of recovery amount;

2. Reasonable payment schedule based on the asset to be recovered; and/or

3. Where not prohibited by law, the imposition of a lien against the assets of the deceased Medicaid recipient.

a. Before the imposition of a lien, the Division shall notify all persons having an interest in the estate of the deceased Medicaid recipient and petition the appropriate district court for the imposition of a lien per NRS 422.29306.

b. If a lien is placed on an individual's home, adjustment or recovery will only be made when:

1. There is no surviving spouse;

2. There is no child under the age of 21; or

3. There is no blind or disabled (as defined in Section 1614 of the SSA) child of the Medicaid recipient.

c. The lien will become due and payable upon the sale, refinance, transfer or change in title to the real property; and/or escrow funding, but only when there is no surviving spouse, children under 21 or blind or disabled children, of any age, as defined by Section 1614 of the SSA of the Medicaid recipient. Recovery is limited to the Medicaid recipient's interest in the property at the time of claim payment not to exceed the Medicaid claim or the percentage of interest of the Medicaid recipient in the asset.

d. Upon payment of the claim, or need of the statutory exemptions, the division will prepare a release of lien or subordinate the lien. This release will be provided to the appropriate entity; such as, an escrow company or the county recorder's office.

803.14 PROCEDURES FOR APPLYING FOR HARDSHIP WAIVER

Federal law prohibits recovery during the lifetime of a spouse and/or when there are children under the age of 21, and/or when there are children who are blind and/or disabled.

A. The State defines undue hardship as severe financial duress or a significant compromise to an individual's health care or shelter needs.

Application for Undue Hardship Waiver – Any heir or survivor may seek an undue hardship waiver by submitting a written request for a waiver by completing an "Application (Request) for a Hardship Waiver Regarding Recovery of Correctly Paid Medicaid Benefits" form within 30 days of notification of the Division's intent to recover. Documentary evidence that supports the applicant's claim should be attached. The written decision of the Administrator of the DHCFP will be provided to the applicant 90 days from receipt of the request.

B. The following time frames are used by the State in considering the waiving of estate recoveries:

1. Any beneficiary, heir or family member claiming entitlement to receive the assets of the deceased Medicaid recipient may apply for a hardship waiver by submitting a written request for a waiver within 30 days of being notified of intent to recover to the MER unit.

2. The Division may request additional information or documentation from the waiver applicant. If some or all the additional information or documentation is not provided within 30 days of the request, the hardship waiver request will be considered solely on the basis of the information and documentation provided.

3. Within 90 days of receipt of the undue hardship waiver request, the Division Administrator or his appointed representative, will issue a written decision granting or denying the applicant's request for an undue hardship waiver.

804 SUBROGATION – THIRD PARTY LIABILITY

804.1 PROVIDERS – CASUALTY LIEN REDUCTIONS

Nevada Medicaid will allow providers who accept(ed) a Medicaid payment for services directly related to injuries or accidents to subsequently return that payment to Medicaid in order to seek reimbursement directly from a liable third party.

A. Medicaid will not enter into an arrangement with providers to represent or act on behalf of Medicaid in pursuit of recovery. Medicaid will continue to utilize its own legal staff to pursue recovery.

B. Medicaid will pursue its own liens against tort settlements/judgments for those payments made by Medicaid to providers who do not repay them to pursue liens of their own. Although one provider may return a payment and pursue its own lien, other(s) may choose to accept Medicaid's payment in full. In these latter situations, Medicaid will pursue its own liens through established subrogation policies. However, the amount of Medicaid's lien will be limited to the total amount of all payments made by Medicaid which were not repaid by providers.

C. Providers have the option to pursue liens on tort actions on a case-by-case basis.

D. Providers are prohibited from pursuing money that has been awarded to a Medicaid beneficiary. The provider is entitled to reimbursement from a tort judgment or settlement only when the settlement distinguishes a set amount of money for medical expenses and only if this amount is above the amount owed to Medicaid. The provider lien must be against the tortfeasor and not the general assets of the beneficiary. In the case of tort liens, on or before 24 months from the date of injury, the provider may return the payment the provider received from Medicaid for the claims related to that injury.

804.2 REPAYMENT OF MEDICAID PAYMENT

Repayment of the Medicaid payment is a waiver by the provider of any further claims against Medicaid based on claims for that injury. Once a Medicaid payment is returned for the purpose of pursuing a tort lien, the provider's claim against Medicaid is ended. Providers who return Medicaid payments to pursue liens will not be allowed to bill Medicaid again at a later date in an effort to secure the entire previously paid Medicaid amount or for payment above the lien recovery amount to secure a minimum of Medicaid's allowable.

A. Repayment to Medicaid must be made prior to any action being taken by the provider to pursue the lien. The pursuit of a lien before returning the Medicaid payments violates federal regulation and the terms of the provider's agreement. In no event may a provider delay returning Medicaid payment until after a settlement or judgment is received.

804.3 PROCEDURES FOR SUBROGATION LIEN REQUEST

The TPL vendor may use a secured maintained system separate from the DHCFP or its contracted Fiscal Agent. The following process outlines details specific to the process for the DHCFP subrogation lead and Chief Financial Officer (CFO). The TPL vendor must provide their system development procedures to review and track for an overview to the DHCFP TPL staff, even in cases where the TPL vendor is acting as the subcontractor to the State's Fiscal agent.

A. The DHCFP lead will receive requests in a secured Excel spreadsheet format from the TPL vendor on a weekly basis via email. The spreadsheet lists specific data for the DHCFP to download for evaluation and to make determinations in the best interest of the State.

The spreadsheet located on the DHCFP shared drive is a back up to what has been evaluated and entered into the TPL vendor system.

B. Once the DHCFP lead reviews, verifies and provides recommendation embedded in the spreadsheet, the CFO is notified of the number of new and/or pending cases that are waiting for review. Once this information has been reviewed, verified and recommendation has been agreed upon or changed by the CFO, then this information will be entered into the TPL vendor system. Once completed, the information will be returned to the TPL vendor so they can notify the attorney or other interested party of the State decision.

1. A case that has already received the state's recommended settlement reduction may be resubmitted to the DHCFP for revalue. The TPL vendor must document the case was resubmitted for a new reduction based on representing attorney request via spreadsheet or through a form of communication.

2. Sample language: "Reduction already proposed at $XX" or "Revalue Request from $XX."

C. The DHCFP lead and CFO will complete this process within ten business days of State receipt for most cases. Longer processing times may apply for appeals, complex cases and requests resulting in a lien reduction of more than $100,000.00 or cases awaiting a response from the DHCFP attorney. If additional time is needed, written communication to the TPL vendor subrogation lead will be required.

804.4 PROCEDURES FOR THE DHCFP

A. LEAD

1. The lead will receive the Casualty Lien Reduction request spreadsheet via secured email.

2. Analyzes spreadsheet, reviews documentation presented for each case as appropriate:

    a. Ensures the required information in the spreadsheet is complete;

        1. Date entered,

        2. Requested status (new, pending or revalue), and

        3. Data contained in the spreadsheet accurately reflects and matches TPL documents provided.

        4. Follows calculation rules outlined in Section 804.5.

    b. If spreadsheet is incomplete or not accurate to information in TPL tracking system, request clarification from TPL vendor.

3. Record lead recommendation for each subrogation case using established guidelines located on spreadsheet. Also, located at the end of this document.

4. For any requests resulting in $100,000.00 or more in settlement or reduction, verify documentation in TPL system:

    a. Any case over $100,000.00 needs to be brought to the attention of the CFO as soon as possible. Add the summary to the email when the reduction request spreadsheet has been saved into the shared drive.

    b. View case breakdown summary attached in TPL system,

    c. Verify with the DHCFP CFO case recommendation direction due to case and lien reduction request and amount.

    d. In certain cases, the CFO may need to submit to the Division's Administrator and the DAG.

5. On a weekly basis, inform the CFO via email the number of cases for that week:

    a. Completed with recommendations for their review and final decision.

    b. **Marked*: "High Importance"* flag.**

    c. Monitor the requests to ensure timely processing by the DHCFP, sending reminders and/or assisting the CFO to manage the requests pending State

decision.

6. Once the CFO provides the State decision;

   a. They will save their final decision within the spreadsheet on the Shared drive; or

   b. The CFO will enter their final ruling in the TPL system for vendor immediate review.

B. CHIEF FINANCIAL OFFICER (CFO):

1. Receive Casualty Lien Reduction requests via email from lead.

2. Reviews recommendations and TPL vendors provided data for each case via spreadsheet and in the TPL vendors system.

   a. Access TPL system to review case documents and TPL vendor notes as needed for case decision.

3. Applies State decisions for each case in TPL vendor system and spreadsheet (spreadsheet is currently a back up to the TPL vendor tracking system).

   a. For cases where there are questions, add notes in the TPL system pending response, notate on spreadsheet in comments field for others to review who may not have TPL system access.

4. Consult with the DAG as needed for complex cases or concerns.

   a. DHCFP DAG for Subrogation:
   Deputy Attorney General
   Department of Health and Human Services
   Division of Health Care Financing and Policy
   Nevada Office of the Attorney General
   555 E. Washington Avenue, Suite 3900
   Las Vegas, Nevada 89101
   (702) 486-3107
   (702) 486-3773 (fax)

5. Once the decisions are made through team discussion (CFO, Lead and DAG), enter finalized case decisions via TPL system and the DHCFP spreadsheet located on the shared drive.

804.5 CALCULATION RULES

The DHCFP's calculation and decision related to the lien reduction request is based on NRS 422.293 guidelines. Nevada developed a combination of Self-Calculated Conditional Payment (SCP) model that enables the State to self-calculate the demand amount before settlement in certain situations, and a Fixed Ratio Option (FRO) reduction amount which offers a simple, straightforward process to obtain the percentage amount due to Medicaid. Based on personal injury case under Mahler vs Szuc (1998), the Mahler Reduction Calculation was developed where Medicaid state agencies recoup one-third of the gross settlement. An additional reduction is determined based on attorney reduction. Logic for the 25% reduction is to help pay for attorney fees and costs.

A. The DHCFP will reduce the total settlement by one-third, and then reduce the one-third by 25%.

B. If the lien is less than one-third of the total settlement then reduce the lien by 25% using the lien amount to help pay for attorney fees and costs.

C. In the lien reduction request, the representing attorney will include an amount that they will accept (an offer). If that amount is more than the amount derived from the above calculations, the DHCFP will accept the attorney's offer.

D. If the representing attorney's offer is less than the amount derived from the above calculations, the DHCFP may counter-offer with the amount resulting from the calculations.

804.6 CONSIDERATIONS

A. Medicaid can only recover the amount paid out for claims related to the accident/injury.

1. Medicaid can only take the lesser of the lien amount or the settlement amount.

B. A lien reduction request will only be considered if the representing attorney or other interested party submits the request in writing.

C. The DHCFP uses a formula to determine equitable, consistent and fair lien reductions based upon the Ahlborn case decision and other case law.

1. As of October 1, 2017, Section 202 of the Act, "Strengthening Medicaid Third-Party Liability" was updated to amend portions of Section 1902(a)(25) to allow state Medicaid agencies to recover funds paid for medical treatment from any tortious settlement or judgment proceeds received by a Medicaid beneficiary. The

states will be permitted to recover from the entire settlement proceeds, not just funds designated as payment for medical care.

D. If Medicaid is taking a loss of over $100,000.00, the State will abide by past interpretation of the one-third rule of the settlement cost and not reduce further.

E. State responses to lien reduction requests must abide by past interpretations of the one-third rule and the guidance from the Nevada Deputy Attorney General's Office.

1. If a request to reduce a Medicaid lien by more than $100,000.00 is received, then the DHCFP CFO must be notified and approve the request.

2. If a request to reduce a Medicaid lien by more than $100,000.00 is received and the CFO is not available, then the DHCFP Administrator must be notified and approve the request.

F. CALCULATION EXAMPLE

	Settlement>Lien	Lien<Settlement	This line is auto populated and will reflect the direction of the decision; Settlement or Lien.
	Name of Victim	Name of Victim	Name of injured person
Gross Settlement	$25,000.00	$15,000.00	Total amount of cash settlement
Gross billed to MCD	$178.582.50	$214,439.37	Total amount billed to Medicaid
MCD Claims	$23,772.26	$22,588.28	Claims Paid by Medicaid
Attorney Reduction Yes or No	NO	YES	
1/3 of Settlement=	$8,333.00	$5,000.00	Auto populated
2/3 of Lien=	$15,856.10	$15,856.10	Auto populated
IF Attorney reduces then 25%		$3,750.00	
Victim Gains	$8,183.00	($51,2871.00)	Amount the victim will retain from injury. The representing attorney can adjust their fees and cost.
Attorney Fees	$8,333.00	$15,000.00	
Attorney Cost	$150.00	$47,521.00	
Total: Fee + Cost =	$8,483.00	$62,521.00	
Attorney Reducing: Yes or No	NO	YES	Attorney reduction also drives collection outcome.
Attorney Offer	$0.00	$0.00	Medicaid disagrees with zero collection. Only in special circumstance would Medicaid accept zero; if the representing attorney takes zero Medicaid will evaluate with the DAG.
Attorney Offer is x% of Lien	0.00%	0.00%	
LEAD Recommendation	$8,333.00	$3,750.00	
CFO Final Offer	$8,333.00	$3,750.00	
Offer is x% of Lien	35.05%	16.60%	
Comment Line	Settlement> Lien + Attorney NOT Reduced	Lien> Settlement + Attorney Reduced	Provide explanation or Notes on case decision.

805 PROBATES

The DHCFP may file a Creditor's Claim with the court for recovery in any probate associated with Medicaid benefits that have been paid on behalf of a deceased recipient. The amount recovered is determined by the assets available in the estate as well as the expenses of the estate.

When a probate has been opened for a deceased Medicaid recipient as a result of a settlement from an accident, injury or from wrongful death, MER will coordinate its claim against the estate of the deceased individual with the subrogation claim of the TPL vendor.

A. When a probate is received in which the estate consists of a settlement relating to an injury from an accident or relating to wrongful death, MER will contact the TPL vendor to determine whether any of the Medicaid benefits paid were related to the accident.

B. If the TPL vendor has a subrogation claim and received payment on their claim, MER will reduce its claim by the total amount of the TPL subrogation claim, regardless of the amount of payment received by the TPL vendor.

C. If the TPL vendor does not have subrogation claims against the estate or does not receive payment on their claim, then MER may submit the full amount of it claims.