Department of HUMAN SERVICES

MEDICAID
TPL ACTION PLAN

Iowa Medicaid Enterprise (IME)

Revised November 7, 2019

I. IDENTIFICATION

A. Collection of Health Insurance Information (other than by the Social Security Administration (SSA)). (See 42 C.F.R. 433.138(b)(1).

1. **What type of health insurance information is gathered from applicants/members (e.g., name of insurer, policy number, name of insured, services covered?)?**

   At the time of application and at periodic re-determinations, the applicant or member receiving Medical Assistance, State Supplementary Assistance, Medical Institution Assistance, Family Assistance Program, and Temporary Assistance to Needy Families must complete a section of the application re-determination form concerning the existence of all health insurance policies. Information requested includes:

   a. Coverage codes
   b. Policy numbers
   c. Name and address of insurance company
   d. Dates of coverage
   e. Policyholder name
   f. Non-custodial parent name and SSN
   g. Relationship of policyholder to member

   Information is loaded or input into the Medicaid Management Information System (MMIS)

2. **Are names, Social Security Numbers and possible third party resources of non-custodial and custodial parents collected from applicants/members?**

   Third party resources of non-custodial parents are collected by the Child Support Recovery Unit (CSRU). CSRU collects the names, social security numbers and insurance information. This information is loaded via electronic processes into the MMIS or entered directly into the TPL Subsystem of the MMIS.

   Third party resources of custodial parents are obtained by various people and activities (see #3), are verified, and then entered into the TPL Subsystem of the MMIS.

3. **Who collects this information (e.g., State agency, county office)?**

   a. TPL information is collected off the Medicaid application and

eligibility system.

At the time of application and at periodic re-determinations, the applicant or member receiving Medical Assistance must complete a section of the application re-determination form concerning the existence of all health insurance policies.

Upon verification of the insurance, the information is loaded into the TPL Subsystem of the Medicaid Management Information System (MMIS) via an electronic file transmission. The Iowa Department of Human Services (the department) outsources all TPL services to a contractor. The states TPL contractor will conduct the TPL work for the Fee-for-Service population

Beginning April 1, 2016, any member in the managed care population will have TPL verified by the Managed Care Organization (MCO). The MCOs have subcontractors in place to do the TPL work. For contractors and subcontractors, refer to ll.D.2.

It is a contractual requirement that the MCOs conduct their own data matches. The activity completed by the MCOs will be monitored by the assigned state staff using auditing tools, such as reports, and encounter data.

b. Other Sources of Information

1. Emails
2. Faxes
3. Telephone Calls
4. Information from providers or other IME Units
5. Absent Parent Reports from CSRU
6. Other insurance information from the Social Security Administration
7. Health Insurance Premium Payment (HIPP) reports

c. TPL subcontractors

The TPL subcontractors for the department and the MCOs use of the following entities in obtaining information on third-party insurance for data match purposes

1. Commercial Insurers
2. Medicare Parts A and B

4. TriCare
5. Pharmacy Benefit Managers
6. Third Party Administrators
7. Self-funded Employer Groups
8. Insurance carriers covering Iowa insureds

4. **When and how is the information verified?**

   The information is verified daily through electronic data match agreements, websites, and calls to insurance carriers.

5. **How is the data transmitted to the Iowa Medicaid Enterprise (IME)? What is the time frame for transmitting the data?**

   The data is transmitted via File Transfer Protocol (FTP) and input directly to the TPL Subsystem of the MMIS daily and weekly. Once input, the data is available immediately.

6. **Where is the verified information maintained (eligibility case file, claims payment system, third party data base, third party recovery unit)?**

   The TPL Subsystem of the MMIS is updated with verified insurance; this information is transmitted to the MCOs. This information is accessible for on-line inquiry.

   The MCOs receive the data from the MMIS TPL subsystem from the department daily using a secure transition protocol. Only MCO approved staff responsible for activities TPL will have access.

7. **What actual information is maintained?**

AUTOMATICALLY POPULATED FIELDS	
NAME OF FIELD	DESCRIPTION
RECIP ID	Member's State I.D. No.
SSN	Member's Social Security No.
SEX	Member's gender
NAME	Member's name
BIRTH	Member's date of birth
DEATH	Member's date of death
PGM	(Aid Type) Basis of Medicaid eligibility
COUNTY	County in which member resides
LAST-TRANS	Last date that screen was updated
USER	User I.D. of person updating file

NAME OF FIELD	DESCRIPTION
NO	Number of insurance record
VER-IND	Indicator that specifies whether information is verified: “good”, “bad”, “terminated” or “not yet verified”
DT-ADD	The date the policy was added to the resource record
ONL-UPD	The last online update
USER	The last user to update
DATE-POL-VERIFIED	The date the policy was verified
1st -CORRES-SENT	The date the first Member TPL letter was sent
BATCH-UPDATED	The date of the last batch update of the MMIS
POL-NUM	Policy number
CARRIER	6 digit carrier code which system uses to generate name and address
HIPP	Indicates HIPP eligibility
POL-TYP	Type of policy, group or single
RETRO	N/A
COV-BEG1N	Date the coverage began
COV-END	Date the coverage ended if applicable
COVER-TYPE	Type of coverage under policy (space for *5 types)*
RELATION	Relationship of policyholder to member
POLICYHOLDER SSN	Social Security Number of policyholder
NAME	Name of policyholder
GROUP NUMBER	Policy group number
AB PARENT	Y/N non-custodial parent indicator
AB PARENT SSN	Social Security Number of non-custodial parent
AB PARENT NAME	Name of non-custodial parent
GROUP NAME & ADDRESS	Name and address of Employer Group
ABSENT PARENT ADDRESS	Name and address of non-custodial parent
COMMENTS	Any comments for this policy and member

8. **How does the TPL file data interface with the claims processing subsystem or other subsystem?**

   The insurance information is entered into the TPL Subsystem of the MMIS.

   The TPL data interfaces with the Claims Subsystem and the MARS Subsystem of the MMIS. During the adjudication cycle, the TPL record is accessed to determine if there is other insurance associated with the claim.

9. **What are the time frames for incorporating the information into the file or files mentioned above?**

Within (45) business days of receipt of third party information, the assigned contractor shall follow up on the information in order to verify legally liable third party resources. State verified information is transmitted electronically to the MMIS TPL Subsystem of the MMIS twice weekly. Manual verifications are performed, verified, and entered daily into the MMIS TPL Subsystem.

Verified TPL by the MCOs is delivered monthly to the MMIS TPL Subsystem.

B. <u>Health Insurance Information Collected by SSA (applies to states having a Section 1634 agreement) (See 42 CFR 433.138(b)(2).)</u>

1. **Who receives the information from the 8019?**

The department receives the 8019 Form from SSA.

2. **How often is the information received?**

Twice a month, SSA sends The DHS, Division of Data Management an electronic report that is then reformatted and delivered to the IME.

3. **When and how is the information verified?**

Twice a month, the IME checks the electronic records to determine if the individual is eligible for Medicaid. At the time the individual appears as eligible on the MMIS member eligibility file, the insurance information is verified and input into the MMIS TPL Subsystem.

Within (45) business days of receiving SSA information the IME Revenue Collections Unit follows up on the information in order to verify legally liable third party resources. These verifications are performed manually, and entered daily into the MMIS TPL Subsystem.

4. **Where is the verified information maintained (eligibility case file, claims payment system, third party data base, third party recovery units)?**

The TPL Subsystem of the MMIS is updated with verified insurance information; this data is transmitted to the MCOs.

5. **What actual information is maintained?**

See chart in section I.A.7.

6. **How does the TPL file data interface with the claims processing subsystem or other subsystems?**

The TPL subsystem is fully integrated and the claims and TPL subsystems of the MMIS interact as describe below.

The insurance information is entered into the TPL Subsystem of the MMIS.

The TPL data interfaces with the Claims Subsystem and the MARS Subsystem of the MMIS. During the adjudication cycle, the TPL record is accessed to determine if there is other insurance associated with the claim. If there is, the TPL matrix (the formula that determines whether a claim is paid, denied, or paid and chased because of a member's insurance information is accessed to determine if that particular third-party insurance actually covers the services being billed. If the claim is covered by the policy and no TPL payment amount is indicated on the claim, the claim is denied. If the claim is covered by the policy and the claim has a TPL amount indicated on it that is equal to or more than the total billed amount, no payment is made. If the TPL amount is less than the Medicaid allowed amount, the balance of the claim is paid up to the Medicaid allowed amount. If the insurance does not cover the service being billed, the claim is paid at the Medicaid allowed amount. If the claim is for pediatric services, or the policyholder is a non-custodial parent, the claim is paid and then billed to the insurance carrier. When a claim is denied because TPL was not billed, it is reported on the remittance advice sent to the provider.

7. **What are the time frames for incorporating the information into the file of files mentioned above?**

Within (45) business days of receipt of the electronic SSA report.

C. <u>Data From the Office of Child Support Enforcement Program</u>

1. **What medical support data elements are being received from the IV-D agency?**

A file of insurance information for child support cases where there is court-ordered medical support and where the member is Medicaid-eligible is transmitted electronically via secure file protocol.

2. **How often is the information received?**

   The information is received on a weekly basis.

3. **When and how is the information verified?**

   The Child Support Recovery Unit verifies the all TPL information with employers before it is sent to the IME Revenue Collections Unit.

4. **Where is the verified information maintained?**

   The TPL Subsystem of the MMIS.

5. **What actual information is maintained?**

   See chart in section I.A.7.

6. **How does the TPL file data interface with the claims processing subsystem or other subsystems?**

   The TPL data interfaces with the Claims Subsystem and the MARS Subsystem of the MMIS. During the adjudication cycle, the TPL record is accessed to determine if there is other insurance associated with the claim. If there is, the system determines whether a claim is paid, denied, or paid and chased because of a member's insurance information is accessed to determine if that particular third-party insurance actually covers the services being billed.

   If the claim is covered by the policy and no TPL payment amount is indicated on the claim, the claim is denied.

   If the claim is covered by the policy and the claim has a TPL amount indicated on it that is equal to or more than the total billed amount, no payment is made.

   If the TPL amount is less than the Medicaid allowed amount, the balance of the claim is paid up to the Medicaid allowed amount.

   If the insurance does not cover the service being billed, the claim is paid at the Medicaid allowed amount.

   If the claim is for pediatric services, or the policyholder is a non-custodial parent, the claim is paid and then billed to the insurance carrier.

When a claim is denied because TPL was not billed, it is reported on the remittance advice sent to the provider.

7. **What are the time frames for incorporating the information into the file or files mentioned above?**

Within (45) business days of receipt.

If the TPL lead is incomplete, investigation is done for verification purposes.

8. **Does the IV-D agency have access to your TPL database?**

No.

9. **Does the IV-D agency verify the current TPL status that the data are correct?**

Yes. The Child Support Recovery Unit verifies this information at the time the court determines which parent is responsible for medical support. Verification is obtained through court documentation and employer verification.

II. DATA EXCHANGES

A. State Wages and Income Collection Agencies (SWICA) and SSA Wage and Earnings Beneficiary Earnings Exchange Records (BEER) Files (See 42 CFR 433.138(d)(1).)

1. **Are you conducting data matches with State wage information collection agencies and SSA wages and an earnings file?**

Yes. Iowa Medicaid receives SSA earnings and pension information from the Beneficiary Earnings Exchange Record (BEER). A file of applicants, members and others whose income is considered for the determination of eligibility for the programs listed above is sent to SSA. SSA returns information on persons having wages, self-employment income, or pension income.

The SWICA Report is received by the Department of Human Services on a quarterly basis from the Iowa Workforce Development. When there is an employed person who is Medicaid-eligible, the information is sent to the DHS caseworker. The DHS caseworker verifies the health insurance information with the

Medicaid-eligible person.

2. **Do you perform this match or does a contractor? If a contractor does it, who is the contractor?**

   DHS is responsible for the match.

3. **Are the names and Social Security numbers of non-custodial parents being matched with SWICA and SSA files?**

   No. Due to State of Iowa law, an employer doing business in Iowa must complete Form 44-109a (8/12/2014), within 15-days of hire or rehire of an employee. The IV-D Agency matches non-custodial parents against new hires and contacts employers for insurance information.

   New hire reporting process was created to help state's child support agencies do the following:

   - locate parents who owe support
   - speed up the payment of support through income withholding

   New hire reporting has been successful in meeting these objectives.

4. **What is the process of conducting the data exchanges? (Include frequency of exchange, use of contractor)**

   The Department of Human Services sends a file of applicants, members and others whose income is considered for the determination of eligibility to the Social Security Administration (SSA). The SSA returns information on persons having wages, self-employment income, or pension income.

   A report is issued anytime a person has income and if a report had previously not been issued in that calendar year. This report is used primarily to indicate unreported income. Information in the report is compared to information in the member's case record. If there is a difference, the applicant or member is contacted to explain the discrepancy. The DHS caseworker verifies the health insurance information with the Medicaid-eligible person.

   The SSA Earnings and Pension Report are filed in the member case file and retained for three years.

5. **How do you follow up on and verify the information to determine if employer group health benefits are available**

directly to the Medicaid members or through a non-custodial or custodial parent?

The department receives a weekly file from the Child Support Recovery Unit (CSRU).

6. **What are the time frames for follow-up?**

The CSRU provides a weekly verified file that is entered into the MMIS TPL Subsystem.

7. **Where is the verified information maintained? (You may refer to Section I.A.6., if appropriate.)**

The information is maintained in the MMIS TPL Subsystem.

8. **What actual information is maintained?**

Refer to section 1.A.7

9. **How does the TPL file data interface with the claims processing Subsystem or other subsystems?**

The TPL data interfaces with the Claims Subsystem and the MARS Subsystem of the MMIS. During the adjudication cycle, the TPL record is accessed to determine if there is other insurance associated with the claim. If there is, the system determines whether a claim is paid, denied, or paid and chased because of a member's insurance information is accessed to determine if that particular third-party insurance actually covers the services being billed.

If the claim is covered by the policy and no TPL payment amount is indicated on the claim, the claim is denied.

If the claim is covered by the policy and the claim has a TPL amount indicated on it that is equal to or more than the total billed amount, no payment is made.

If the TPL amount is less than the Medicaid allowed amount, the balance of the claim is paid up to the Medicaid allowed amount.

If the insurance does not cover the service being billed, the claim is paid at the Medicaid allowed amount.

If the claim is for pedicatric services or the policyholder that is a non-custodial parent, the claim is paid and then billed to the insurance

carrier.

When a claim is denied because TPL was not billed, it is reported on the remittance advice sent to the provider.

10. **What are the time frames for incorporating the information into the file or files mentioned above?**

(45) business days from file receipt.

11. **Do you receive information from the IV-A agency that identifies Medicaid Members who are employed and their employer(s)? If not, how do you obtain information for this population?**

The Department of Human Services is both the Medicaid Single State agency and the IV-A agency. There is not a separate IV-A agency. At the time of application and at periodic re-determinations, the applicant or member of Medical Assistance, State Supplementary Assistance, Medical Institution Assistance, Family Assistance Program, and Temporary Aid to Needy Families must complete a section of the application re-determination form concerning the existence of all health insurance policies.

B. **<u>Workers' Compensation</u>**

1. **Are you conducting data matches with the State's Workers' Compensation agency?**

The department determined that it was not cost effective to perform this match due to the fact that departments' effective Trauma Edit Project was a duplicate effort.

ICD-10 codes related to accidents or injuries are identified on members paid claims. Questionnaires are sent to members each month who are identified as having an accident or injury. If the initial questionnaire is not returned, a second request is sent. If no response is returned, and the member is over 21 year of age, the member's Medicaid eligibility will be sanctioned until they comply.

2. **Do you perform this match or does a contractor? If a contractor does it, who is the contractor?**
3. **What is the process for conducting the data exchange? (Include frequency of exchange).**
4. **Are the names and SSN's of non-custodial parents being**

matched?

5. **How do you follow up on and verify the information to determine if a Medicaid Member has an employment related injury or illness?**
6. **How do you follow up on and verify the information to determine if employer group health benefits are available directly to a Medicaid Member or through a non-custodial or custodial parent?**
7. **What are the time frames for follow up?**
8. **Where is the verified information maintained?**
9. **What actual information is maintained?**
10. **How does the TPL file data interface with the claims processing subsystem or other subsystems?**
11. **What are the time frames for incorporating the information into the file or files mentioned above?**
12. **If you are not conducting data exchanges with Worker's Compensation, was a reasonable attempt made to do so? If yes, did you submit documentation with Attachment 4.22B of the State Plan?**

C. State Motor Vehicle Accident Report Files

1. **Are you conducting data matches with State motor vehicle accident report files?**

   DHS determined that it was not cost effective to perform this match due to the fact that DHS' effective Trauma Edit Project was a duplicate effort.

   The IME tracks the trauma related accidents/incidents by ICD-10 codes.

2. **Do you perform this match or does a contractor?**

3. **Describe the process for conducting the data exchange.**

4. **How do you follow up on and verify the information to identify those members injured in motor vehicle accidents (pedestrians, drivers, or passenger)?**

   Information is requested of the member regarding an accident or injury. If the member indicates an accident or injury the case is evaluated to determine the need for further investigation. Examples of the types of considerations made include circumstances of the accident as related by the member and total Medicaid dollars spent. Types of expanded investigation which may be done include

contacting the property or automobile owner, the insurance company, health care providers, and/or attorneys directly.

5. **How do you follow up on and verify third party resources that would be available through an automobile or liability insurance policy?**

All correspondence indicating an accident or injury is investigated. Contact is made with liability insurance, and/or an attorney for verification, notification and subrogation. A recovery file is opened for any members who indicate third party liability or attorney involvement.

6. **What are the time frames for follow up?**

Within forty-five (45) business days of receipt the information identified in Section I.A.3. is investigated.

7. **Where is the verified information maintained? (Refer to Section I.A.6. if appropriate)**

Refer to Section I.A.6.

8. **What actual information is maintained?**

Refer to Section I.A.7.

9. **How does the TPL file data interface with the claims processing subsystem or other subsystems?**

Refer to Section I.A.8.

10. **What are the time frames for incorporating the information into the file or files mentioned above?**

Within forty-five (45) days of receipt, the information identified in Section I.A.3. is investigated.

11. **If you are not conducting data exchanges with State Motor Vehicle Accident Report Files, was a reasonable attempt made to do so? If yes, did you submit documentation with Attachment 4.22B of the State Plan?**

No, The IME is not conducting matches. The trauma related accidents/incidents by ICD-9/ICD-10 codes are tracked.

D. Other Data Exchanges

1. **What other data exchanges do you conduct (e.g., private insurers, Defense Enrollment Eligibility Reporting System (DEERS), credit bureaus, fraternal organizations, unions)?**

   The TPL contractor for the state will annually conduct the DEERS data match for the entire Medicaid population, including those members assigned to a Managed Care Organization (MCO). The DEERS match collects Tricare health care information on active duty military, active duty service families, retirees and their families, and other beneficiaries.

   Beginning April 1, 2016, any member in the managed care population will have all other TPL verified by the MCO. The MCOs have subcontractors in place to conduct their own data matches

   It is a contractual requirement that the MCOs conduct their own data matches. The activity completed by the MCOs will be monitored by the assigned state staff using auditing tools, such as reports, and encounter data.

   For a list of data matches, refer to Section 1.A.3.b and c.

2. **Do you perform the match or does a contractor? If a contractor does it, who is the contractor?**

3. **Are the names and SSN's of non-custodial and custodial parents being matched?**

   The names and SSN's of non-custodial and custodial parents are matched when the information is available.

4. **What is the process for conducting the data exchanges? (Include frequency of exchange).**

   Medicaid eligibility data is matched with eligibility data of other insurers. The eligibility data is obtained from their web sites or eligibility data files daily, weekly or monthly, depending on the carrier.

   All information that matches is loaded into the TPL Subsystem of the MMIS twice weekly.

5. **How do you follow up and verify the information?**

Prior to loading all insurance information the TPL Subsystem of the MMIS the data is verified with the insurer/third party.

6. **What are the time frames for follow up?**

   The data is loaded into the TPL Subsystem of the MMIS within (45) business days of receipt. The information is verified with insurers/third parties daily.

7. **Where** is **the verified information maintained? (You may refer to I.A.6, if applicable).**

   The TPL Subsystem of the MMIS is updated with verified insurance; this information is transmitted to the MCOs. This information is accessible for on-line inquiry.

8. **What actual information is maintained?**

   Refer to Section I.A.7.

9. **How does the TPL file data interface with the claims processing subsystem or other subsystems?**

   Refer to Section I.A.8.

10. **What are the time frames for incorporating the information into the file or files mentioned above?**

    Within (45) business days from the receipt, the information is input into the TPL Subsystem of the MMIS.

III. DIAGNOSIS AND TRAUMA CODE EDITS

1. **Are you conducting diagnosis and trauma code edits for codes 800 through 999, with the exception of code 994.6? If not, list codes, which are not being edited.**

   ICD-10 trauma related codes are programed.

2. **Do you conduct the diagnosis and trauma code edits or does a contractor? If a contractor does it, who is the contractor?**

   The IME contracts with Noridian to conduct the diagnosis and

trauma code matches for the Fee-for-Service population.

The MCO contractors conduct the diagnosis and trauma code matches for the managed care population. The MCO contractors are:

- Amerigroup Iowa, Inc.
- United Healthcare Plan of the River Valley, Inc.
- Iowa Total Care contracts with The Rawlings Company.

3. **What is the process? (Include frequency of conducting edits)**

On a monthly cycle members with paid claims showing a trauma diagnosis code are reported by the contractors.

4. **How do you follow up on and verify the information to identify possible trauma related injuries?**

Questionnaires are sent to members each month. If the initial questionnaire is not returned, a second request is sent. If no response and the member is over 21 year of age, the member's Medicaid eligibility will be sanctioned until they comply.

5. **How do you follow up on and verify that third party resources may be available through a liability insurance policy?**

When questionnaires are returned by members indicating that the liable third party has liability insurance, or when the member has retained the services of an attorney for possible litigation, the contractor opens a subrogation case and files a lien. Submitted claims are processed by the department or the MCO contractors during any settlement, negotiation, or litigation.

The department or the MCOs will pay claims and then settle with the liable third party after a settlement or a court award is made.

6. **What are the time frames for follow up?**

Within forty five (45) business days of receipt of the information identified in Section I.A.3.

7. **Where is the verified information maintained?**

All lien recovery information is maintained in a case management database.

8. **What actual information is maintained?**

Electronic case information includes:

a. Name of Member
b. Documentation of why case was opened
c. Name and address of attorney
d. Certification of notice to parties
e. Letters of representation
f. Patient waivers for release of information
g. Name and address of insurance carrier for liable third party
h. Case history

The file also includes documentation of telephone conversations, copies of correspondence and liens, and any other information that may be gathered as the case progresses.

9. **How does the TPL file data interface with the claims processing subsystem or other subsystems?**

The information is maintained in a database. Once the case is settled and payment is received from the liable third party, adjustments are made in the claims processing subsystem in the MMIS to reflect reimbursement of these claims. A final lien is not filed until the course of treatment is complete and claims submitted.

Once a settlement is agreed upon, the subrogation case is considered closed. Settlements do not include future medical cost.

10. **What are the time frames for incorporating the information into the file or files mentioned above?**

Upon receipt of reimbursement, postings are entered within twenty (20) business day into the database.

IV. CLAIMS PAYMENT

A. Cost Avoidance (see 42 C.F.R. 433.139(b)(1).)

1. **Which claim types, member populations, etc. are you cost avoiding?**

All claims for members with TPL are cost avoided except for claims for EPSDT (to include preventive pediatric services) and IV-D enforceable claims, which are paid and chased.

2. **What information is available through the member's Medicaid**

identification medium, if any, indicating third party resources?

MMIS transfers insurance information to the State's eligibility system for informational purposes only. Providers verify eligibility through the Eligibility Verification System (ELVS) and the TPL information that is maintained on the MMIS is included in the automated response message.

3. **What is your process for cost avoiding claims? (Include use of contractor)**

The TPL data interfaces with the Claims Subsystem. During the adjudication cycle, the TPL record is accessed to determine if there is other insurance associated with the claim. If there is, the TPL matrix (the formula that determines whether a claim is paid, denied, or paid and chased because of a member's insurance information) is accessed to determine if that particular third-party insurance actually covers the services being billed.

The IME claims processing system contains TPL coverage codes. If the claim system recognizes the applicable coverage code and no TPL payment amount is indicated on the claim, the claim is denied. If the claim has a TPL amount reported equal to the total billed amount, no payment is made.

If the TPL amount is less than the Medicaid allowed amount, the balance of the claim is paid up to the Medicaid allowed amount.

If the insurance does not cover the service being billed, the claim is paid at the allowed amount.

If the claim is fora pediatric service, or a member with a policyholder that is a non-custodial parent, the claim is paid and then billed to the insurance carrier.

4. **How are electronic billers providing evidence of third party pursuit?**

Electronic claims capture TPL paid amounts and denial indicators. Electronic claims are processed the same as paper claims.

5. **How do you control and verify the partial payment of claims (hard copy and electronic) after the third party has made payment?**

A claim that is received indicating a third party payment must include

the amount of the third party payment. The claim is priced, and the TPL payment is subtracted. If the TPL amount is less than the allowed amount, the balance of the claim is paid up to the allowed amount.

6. **What method do you use for tracking cost avoided dollars (as reported on the 64.9a, Medicaid Expenditures Report)?**

Cost avoidance is a function of reported TPL on claims and claims that have been denied where TPL exists but has not been reported by the provider.

For the Fee-For-Service population, this is tracked by the MMIS, using monthly hard coded reports.

It is a contractual requirement that the MCOs report cost avoidance to the department. The activity completed by the MCOs will be monitored by the assigned state staff using auditing tools, such as reports, and encounter data.

a. **How do you account for initial claims and reconcile the amount when the claims are resubmitted?**

The departments' TPL contractor for the Fee-for-Service population will use monthly hard coded reports produced by the MMIS, that report claims paid and TPL payments.

It is a contractual requirement that the MCOs report cost avoidance to the department. The activity completed by the MCOs will be monitored by the assigned state staff using auditing tools, such as reports, and encounter data.

b. **Do you have a method for measuring cost avoided dollars for claims that are never received by the State? (If yes, describe the method.)**

No. Given the difficulties recognized by CMS in attempting to measure such dollars, Iowa does not intend to implement a formula at this time, which would attempt to estimate those cost savings.

c. **Do you account for claims denied for cost avoidance purposes only up to the Medicaid payment limit?**

Yes

d. **Do you include Medicare or count it separately?**

Medicare is counted separately.

e. **Do you include member co-payments?**

Co-payments included with the billed claim as unpaid expense.

f. **What do you include under "other cost avoidance?"**

Nothing

B. Pay and Chase Recovery

1. **Which claim types are you paying and chasing? For which do you have waiver? Explain those for which you do not have waiver.**

All claims for members with TPL are cost avoided except for EPSDT (including preventive pediatric services) and IV-D enforceable claims which are required to be paid and chased. A confidentiality exception is grant by eligibility staff and the indicator is pulled into the MMIS system. A person can claim good cause due to confidentiality if the person is fearful of the consequences. A person can also claim good cause for not cooperating in filing a claim for health insurance. Members with confidentiality identifiers in the MMIS are not paid and chased.

The MMIS system will track whether a member has confidentiality exception, and the indicator will be passed to the MCOs in a daily file.

2. **Are you currently paying and chasing claims in accordance with 42 C.F.R. 433.139(b)(3)(i) and (ii)? (This section applies to claims for services for prenatal care for pregnant women, preventive pediatric services or covered services furnished in cases where the third party resource is derived from the non-custodial parent whose obligation to pay third party medical support** is **enforced by the State Title IV-D Agency).**

The TPL contractor for the state will pay and chase for the Fee-for-Service population, as well as for anyone with active Tricare.

It is a contractual requirement that the MCOs pay and chase. The pay and chase activity completed by the MCOs will be monitored by the assigned state staff using auditing tools, such as reports, and encounter data.

3. **Do you currently have recovery threshold amounts? If so, what are they and how were they determined? For threshold amounts greater than $100 for health insurance and greater than $250 for casualty claims, provide documentation including calculations showing that the threshold amounts are cost-effective.**

Health insurance claims thresholds:

- HMS Inc., the TPL contractor for the department, the threshold is $100.00
- Amerigroup Iowa, the threshold is $24.99 per claim.
- Iowa Total Care, the threshold is $100.00.
- United Healthcare Plan of the River Valley, Inc., the threshold is $20.00.

Health casualty claims thresholds:

- HMS Inc., the TPL contractor for the department, the casualty claims threshold is set at $250.00 unless notification comes directly from an attorney or casualty carrier, then the threshold is $50.00. It is not cost effective to pursue a potential recovery below $250.00 unless notified by an attorney or casualty carrier.
- Amerigroup Iowa, the threshold is $250 in accumulated claims.
- Iowa Total Care, the threshold is $250.00.
- United Healthcare Plan of the River Valley, Inc., the threshold is $500.00
    - United Healthcare believes this is cost-effective because the rate of false positive identifications (cases identified with no recovery potential) increases significantly at lower thresholds for electronic case identifications. Although the threshold for electronic case identifications is at $500 in paid claims matching our diagnosis codes, we do also investigate claims based on referrals sent to our team, regardless of the paid claim amount.
    - The threshold was developed by United Healthcare after considering administrative costs in identifying and pursuing recovery efforts, as well as minimizing member abrasion.

4. **Does the thresholds include accumulated billing? If so, over what period of time?**

   Yes, the threshold accumulates for one year.

5. **How does the system identify when threshold levels are reached?**

   Within ninety (90) business days of receipt of the claims information identified in Section I.A.3., the contractor follows up on such information in order to identify legally liable third party resources.

6. **What is your process for seeking recovery? (Include use of contractor).**

   The departments' TPL contractors for the Fee-for-Service and MCO population are required to pay and chase claims where insurance coverage has been found after payment of a claim, and mandated pay and chase is required by law.

   The contractors are:

   - HMS Inc. the TPL contractor for the department.
   - Amerigroup Iowa, Inc., and their subcontractors:
     - ❖ Council for Affordable Quality Healthcare (CAQH)
     - ❖ HMS
     - ❖ Optum Insight
   - Iowa Total Care, and their subcontractors are:
     - ❖ HMS
     - ❖ The Rawlings Company
   - United HealthCare Plan of the River Valley, Inc., and their subcontractors:
     - ❖ HMS
     - ❖ Optum Insight

   a. **What codes, if any, are used for recovery purposes (e.g., HCPCS, diagnosis codes, other procedure codes)?**

      Codes included on paid claims where retroactive insurance has been found claims are passed to the insurance company for reimbursement.

   b. **How does the system identify individual claims for recovery? (See Section IV. B.6).**

      When retroactive insurance has been found claims are

passed to the insurance company for reimbursement.

c. **In what order and from whom do you seek recovery?**

All health insurance carriers are billed for any qualified claim paid with Medicaid dollars for which there is third party insurance coverage on a member's record.

d. **How do you follow up to assure that collection was made? What are the specific accounting and reporting procedures for recoveries?**

The contractors track initial billings to see if an disposition of the claim has been received, if not, multiple follow-up procedures including rebilling, contacting third parties, and targeting claims with high likelihood of recovery for aggressive follow up.

e. **If collection was not made, how does the system trigger follow up?**

The IME Revenue Collections Unit yield management staff monitors by following up on the high dollar and large volume of claims that have been denied or unprocessed by the carrier within ninety (90) business days. The IME Revenue Collections Unit contacts insurance carriers requesting a status on unpaid billings. If necessary, the claims will be re-billed to the carrier and follow up will be conducted until claims are processed or denied.

It is a contractual requirement that the MCOs report recovery activity to the department. The activity completed by the MCOs will be monitored by the assigned state staff using auditing tools, such as reports, and encounter data.

f. **How do you track actual dollars recovered?**

A monthly report details amounts billed and collected.

g. **How are TPL recoveries reconciled with the claims history? Specify the audit and control procedures followed.**

Monthly, Fee-for-Service collections are posted back to the original claim in the form of an adjustment.

The contractor for Fee-for-Service, HMS, reviews a random selection of 3% of adjustments. An adjustment is made to correct any errors discovered.

It is a contractual requirement that the MCOs post back collection to the original claim. The assigned state staff will monitor this activity using encounter data.

h. **What are the specific procedures for recovery in casualty cases involving settlement awards?**

The state Medicaid agency is limited by the U.S. Supreme Court's decision, in *Arkansas Department of Health and Human Services, et al. v. Ahlborn, 547 U.S. (2006),* to recover only form the portion of a settlement or award that is designated for payment of medical expenses. This medical settlement amount is intended to pay all medical expense claims, including Medicaid's claim and claims from providers who didn't accept Medicaid's payment for their services.

If an amount offered in settlement is less than 100% of the lien amount, the proposal is referred to the Department of Human Services for review and approval. Requests that the Department of Human Resources reduce a Medicaid lien amount or waive the amount altogether are based upon the United States Supreme Court Decision. [See *Arkansas Department of Health and Human Services, et al. v. Ahlborn, 547 U.S. (2006)]*.

This decision requires that State Medicaid Programs only recover their percentage share of the settlements that are attributable to medical costs, regardless of the total value of the incurred medical costs.

i. **Do you have any formal billing arrangements or agreements with private insurers? If so, describe. (Include the information shared/requested, time frames, and how outstanding claim amounts are reconciled).**

Data exchange agreements and billing arrangements with multiple third parties.

The contractors contact insurance carriers requesting a status on unpaid billings. If necessary, the claims will be re-billed to carrier and follow up will be conducted until claims are processed or denied.

Information shared - if there is a match with member eligibility, a review of the dates of service on all paid Medicaid claims is made to determine if other insurance coverage was applicable during that time and, if so, the insurance carrier is billed for those claims.

The contactors monitor yield recovery by following up on the high dollar and large volume of claims that have been denied or unprocessed by the carrier within ninety (90) business days and contacts insurance carriers requesting a status on unpaid billings. If necessary, the claims will be re-billed to the carrier and follow up will be conducted until claims are processed or denied.

V. OTHER

1. **Do you pay premiums for health insurance policies if it is determined to be cost effective? If so, please provide methodology for determining cost effectiveness.**

SUMMARY OF STATE PLAN UNDER TXIX OF THE SOCIAL SECURITY ACT

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 4.22-C
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Iowa

Citation	Condition or Requirement
1906 of the Act 1905(a) of the Act	State Method on Cost-Effectiveness of Employer-Based Group Health Plans

This explains the State of Iowa's methodology for determining the cost-effectiveness of paying health insurance premiums for employer sponsored health insurance, individual, or COBRA policies. Member enrollment in employer sponsored health insurance, individual, or COBRA policies is voluntary.

Iowa's formula for determining cost-effectiveness of insurance plans is as follows:

A health insurance plan shall be considered cost-effective when the amount that the Medicaid agency would pay in total for all premium, cost sharing, benefit wrap obligations under a health plan, plus an amount for administrative costs, is likely to be less than the amount paid for an equivalent set of Medicaid services.

When determining cost effectiveness of a health insurance plan the agency shall consider the following:

1. The estimated cost to Medicaid for the member's cost sharing including employee premium contributions and surcharges, deductible, coinsurance, out-of-pocket maximum, copayments, and cost sharing wrap. No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.

2. Cost of benefits that are not in the private insurance plans, provided on a Fee-for-Service basis that would otherwise be included in the Medicaid state plan, (i.e. wrap benefits).

3. Administration cost.

4. The average per member cost of services to the Medicaid agency. This is the managed care capitation payment that varies based on the eligible member's sex, age, and eligibility aid type.

If the formula indicates that the policy is not cost-effective based on average Medicaid expenditures for similar households, the specific health-related circumstances of the household are examined. Group health insurance will be purchased if the household's anticipated medical expenditures are enough higher than average to make the policy cost-effective.

2. **What other TPL practices, not covered above, do you pursue? For example, do you pursue estate recoveries? Please describe how you approach any of these "other" practices.**

   The departments' estate recovery work is done by HMS, who subsequently subcontracts the work to The Sumo Group. The Sumo Group pursues all estate recovery as part of the third party liability collections function. The approach utilized for estate recovery collections is dependent on five (5) primary processes: (1) transfer of member information from active case file status to estate recovery case management that includes managing data from multiple sources, eligibility information and claims on MMIS; (2) implementation of a comprehensive program for asset identification on estates subject to recovery that include banking information, probate claims, identifying appropriate cases to file claims against estates, personal representative, funeral home, and DHS caseworker; (3) Identification of the deceased member's estate manager and a process for appropriate alternate action if a non-probated estate does not have an authorized representative including banking information, probate claims, contacting personal representative, identifying appropriate cases to file claims against estates which consist of determining if exemptions exist, if there is a debt and filing claims against estates; (4) development and implementation of a comprehensive educational program targeted specifically to estate recovery stakeholders and related parties including, but not limited to, DHS caseworkers, Medicaid members and their families, State of Iowa Bar Associations, State Funeral Home Directors, State Nursing Home Directors, State Attorney General and State Policymakers; and (5) development of a process to review and enhance existing State Statutes and Rules to ensure a robust statutory authority exists for the Estate Recovery Program, and development of a Model Statute which could be offered in other states.

3. **Do you use a contractor for any other TPL activities not covered here? If so, identify the contractor and describe the specific types of activities performed.**

   No