IOWA DEPARTMENT OF HUMAN SERVICES

MEDICAID
TPL ACTION PLAN

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TPL ACTION PLAN
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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) by way of applicable indicators determined by responses on the Insurance Questionnaire (IQ) (**Attachment "A"**).

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

The names, social security numbers and possible third party resources of non-custodial and custodial parents are obtained by the Child Support Recovery Unit (CSRU) and entered into the TPL Subsystem of the MMIS on a weekly basis. The above-referenced information is also requested on the Insurance Questionnaire (IQ). When information is obtained from the IQ, it is verified via telephonic or website verification and loaded via electronic processes into the MMIS or entered directly into the TPL Subsystem of the MMIS.

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

Sources of insurance information include:

a. Insurance Questionnaire (IQ)

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 Aid to Needy Families 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.

b. Other Sources of Information

1. Emails
2. Faxes
3. Telephone Calls
4. IQ's 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. Iowa Medicaid Enterprise Revenue Collections Unit

The IME Revenue Collections Unit makes 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

The information is used to perform retroactive recovery of

Medicaid funds. Also, when the insurance is verified, it is loaded into the TPL Subsystem of the MMIS for all matched individuals. Procedures for data exchanges are discussed more thoroughly in Section II of this Action Plan.

d. Workers' Compensation

DHS determined that it was not cost effective to perform this match due to the fact that DHS' Trauma Edit Project was a duplicate effort. (See Section III, Diagnosis and Trauma Code Edits, Paragraph 3).

e. Motor Vehicle Accident Records

The former TPL contractor performed a cost effectiveness analysis on the project, which demonstrated the project not to be cost effective. The former contractor provided this analysis to DHS on September 11, 1996. The analysis indicated:

1. The Department of Transportation file did not contain many accident related records associated with Medicaid members, and

2. Many of the accident related records identified through this project were duplicative of DHS' Trauma Edit Project.

(See Section III, Diagnosis and Trauma Code Edits, Paragraph 3).

f. SWICA

Iowa Medicaid matches the eligibility file with the State Wage Information collection Agency (SWICA). A match is completed upon initial application and quarterly thereafter. If it is new or different information, the DHS caseworker will contact the member for an explanation and also inquire about possible insurance coverage. If there is insurance coverage available, the DHS caseworker will have the member complete the IQ and will make a referral to the Health Insurance Premium Program (HIPP), if appropriate.

g. MMIS Claims Subsystem

1. Trauma Code Reporting

The IME Revenue Collections Unit receives a Trauma Leads Report – IAMT1600-R001 (**Attachment "B"**) at the end of each month showing members who have had claims paid with trauma diagnosis codes. A full discussion of the procedures associated with this report can be found in Section III of this Action Plan.

2. Possible existence of other insurance editing

At the time the claim is entered into the TPL Subsystem of the MMIS, any third party insurance payment that is indicated on the claim is recorded. If other insurance is indicated and there is no insurance information in the TPL Subsystem of the MMIS, the TPL edit (266) fails, which triggers the production of a monthly TPL Leads Report – IAMT1600-R006 (**Attachment "C"**). Additionally, questionnaires (Other Insurance Request) (**Attachment "D"**) are generated by the MMIS and sent to the member requesting insurance information. The IME Revenue Collections Unit then investigates this information.

3. Probable existence of other insurance

h. If there is insurance information for a member in the TPL Subsystem of the MMIS, and there is no insurance payment or denial indicator with the claim, all claims for that member will fail for probable existence of TPL or multiple occurrences of TPL (edit *265).* The failure of these edits causes the system to deny the claim and send the message back to the provider on the remittance advice to bill other insurance first.

i. IV-D Agency

The Child Support Recovery Unit sends a weekly file to the IME Revenue Collections Unit, which includes insurance information when coverage is provided by a non-custodial parent.

4. **When and how is the information described in Paragraph 3 verified?**

a. IQ

IQ's sent to the Iowa Medicaid Enterprise are forwarded to the IME Revenue Collections Unit to verify with the third party insurer. Upon verification from the applicable insurance carrier, insurance information for qualifying policies is loaded to the TPL Subsystem of the MMIS through an electronic file transmission.

When a completed IQ is returned from DHS caseworkers and providers, the document is scanned, verified, and the information is loaded into the TPL Subsystem of the MMIS.

b. IME Revenue Collections Unit

Periodically, the IME Revenue Collections Unit matches the Medicaid eligibility file with the eligibility files for Medicare (Part A) and for selected commercial carriers. For those members with coverage listed above, who do not have the Third Party Liability (TPL) insurance coverage, indicated on their Medicaid eligibility record, the IME Revenue Collections Unit bills providers for hospital claims where the original claim was filed on a UB04, rather than filed as a crossover claim. The commercial insurance coverage information is also verified and posted to the TPL Subsystem of the MMIS and is used in determining future cost avoidance of claims.

c. Workers' Compensation

Not applicable - see Section I.3.D.

d. SWICA, SSA, IV-A

SWICA - Iowa Medicaid matches the eligibility file with the State Wage Information Collection Agency (SWICA). A match is completed upon initial application and quarterly thereafter. If it is new or different information, the DHS caseworker will contact the member for an explanation and also inquire about possible insurance coverage. If there is insurance coverage available, the DHS caseworker will have the member complete the IQ and make a referral to the HIPP Program, if appropriate. When the IME Revenue Collections Unit receives the IQ, the verification process is initiated.

SSA - SSA Form 8019-U2 information is verified by the IME

Revenue Collections Unit. A report is received from the Data Management Division of the Department of Human Services and is incorporated into the verification process.

e. IV-A Agency

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.

f. MMIS Claims Subsystem

1. Trauma Code Reporting

When the Trauma Lead Letter (see **Attachment "E"**) is returned to the IME Revenue Collections Unit, the answers and diagnosis codes are reviewed for potential recovery. All insurance information is input into a case tracking system to match the trauma-related claims with the trauma incident. The IME Revenue Collections Unit requests reimbursement from other parties, such as other insurance carriers, for claims that were paid by Medicaid but are the legal responsibility of a third party.

2. Possible existence of other insurance

At the time the claim enters the MMIS System, any insurance information is noted. If other possible insurance information is indicated on the claim, but is not in the TPL Subsystem of the MMIS, an exception posts and the information is reported and the Third Party Lead Letter is automatically generated and sent to the member. When this letter is returned, the information is verified and then transferred to the TPL Subsystem of the MMIS.

g. IV-D Agency

The Child Support Recovery Unit (CSRU) receives employment information. If there is a medical support order for a child, the insurance information is verified by CSRU and transmitted to the IME Revenue Collections Unit. The IME Revenue Collections Unit enters the insurance information into the TPL Subsystem of the MMIS.

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

   a. Electronic Data Matches

      1. Electronic data matches with insurers and other entities are currently performed by the IME Revenue Collections Unit. Verified information is transferred electronically to the TPL Subsystem of the MMIS on a twice-weekly basis.

   b. Hard Copy Data

      1. All hard copy information is entered into the IME's imaging system and the IME Revenue Collections Unit completes the verification process within 10 business days of receipt of the information. For quality assurance purposes, a sample is pulled from the original documents and verified against data in the TPL Subsystem of the MMIS.

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 accessible by the claims payment system during adjudication cycles. It is also accessible for on-line inquiry.

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

   The following information is maintained within the TPL Subsystem of the MMIS (**Attachment "F"**).

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)* **(See Attachment "G")**
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. 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) (see **Attachment "H"**) 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, per the TPL matrix, the claim is paid at the Medicaid allowed amount. If the claim is for pediatric or prenatal services, or the policyholder is a non-custodial parent, the claim is paid and then billed to the insurance carrier by the IME Revenue Collections Unit. When a claim is denied because TPL was not billed, it is reported on the remittance advice sent to the provider.

The recovery efforts are reported, at a minimum, by reports that list out dollars cost avoided by coverage type and by provider type, and identifies total Medicare payments for Parts A and B.

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

   a. All sources

      Within 10 business days of receiving complete third party information the IME Revenue Collections Unit follows up on the information in order to verify legally liable third party resources. Verified information is transmitted electronically to the TPL Subsystem of the MMIS twice weekly.

B. Health Insurance Information collected by the Social Security Administration (SSA) (applies to states having a Section 1634 Agreement).

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

   The Department of Human Services receives the 8019 Form from SSA.

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

   The Social Security Office mails the 8019 Form to the Department of Human Services at the time that Supplemental Security Income (SSI) application is filled out. The client has not been determined to be eligible or ineligible at the time the Department of Human Services receives the 8019. The DHS, Division of Data Management produces a hard-copy report twice a month that is delivered to the IME Revenue Collections Unit in a locked bag.

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

   Twice a month, the IME Revenue Collections Unit checks each 8019 form 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 TPL Subsystem.

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

   Refer to Section I.A.6., Page 7.

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

   Refer to Section I.A.7., Pages 7 and 8.

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

   Refer to Section I.A.8., Page 9.

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

   The IME Revenue Collections Unit follows up, within ten (10) business days of receiving complete information identified in Section I.A.3, in order to identify legally liable third party resources and incorporates the information into the TPL Subsystem of the MMIS.

C. Data From the Office of Child Support Enforcement Program

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

   Insurance information gathered from the non-custodial parent or employer is entered on the Iowa Collection and Reporting System (ICAR). The ICAR System has four screens, which allow the Child Support Worker to add, modify, and delete medical information. A file of insurance information for child support cases where there is court-ordered medical support and where the member is Medicaid-eligible is sent electronically to the Iowa Medicaid Enterprise. The IME Revenue Collections Unit obtains this information, reformats it, and electronically loads it to the TPL Subsystem of the MMIS.

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 information with employers before it is sent.

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

   Refer to Section I.A.6., Page 7.

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

   Refer to Section I.A.7., Pages 7 and 8.

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

   Refer to Section I.A.8., Page 9.

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

   Within ten (10) business days of receiving complete information identified in Section I.A.3 by the IME Revenue Collections Unit.

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. <u>State Wages and Income Collection Agencies (SWICA) and SSA Wage and Earnings Beneficiary Earnings Exchange Records (BEER) Files</u>

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 this match.

3. **Are the names and Social Security numbers of non-custodial parents**

being matched with SWICA and SSA files?

No. Due to State law, all new hires are reported to DHS via Form 44-109a (5/23/02). The IV-D Agency matches non-custodial parents against new hires and contacts employers for insurance information. (**Attachment "I"** - Centralized Employee Registry Reporting Form.)

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?**

When the Medicaid member indicates health insurance exists, a Insurance Questionnaire (IQ)(**Attachment "A"**) is sent to the member. This IQ requests information about the availability of other insurance.

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

The IME Revenue Collections Unit follows up, within ten (10) business days of receipt of the information from the DHS caseworker identified in Section I.A.3., on such information in order to identify legally liable third party resources and incorporates such information into the TPL Subsystem of the MMIS.

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

   Refer to I.A.6., Page 7.

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

   Refer to Section I.A.7., Pages 7 and 8.

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

   Refer to Section I.A.8., Page 9.

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

    The IME Revenue Collections Unit follows up on such information, within ten (10) business days of receiving complete information identified in Section I.A.3., in order to identify legally liable third party resources and incorporates such information into the TPL Subsystem of the MMIS.

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?**

   DHS determined that it was not cost effective to maintain this match, due to the fact that DHS' effective Trauma Edit Project was a duplicate effort. (See Section III, Diagnosis and Trauma Code Edits, Paragraph 3.).

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

   Not applicable.

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

   Not applicable.

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

   Not applicable.

5. **How do you follow up on and verify the information to determine if a Medicaid Member has an employment related injury or illness?**

   Not applicable.

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?**

   Not applicable.

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

   Not applicable.

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

   Not applicable.

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

   Not applicable.

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

    Not applicable.

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

    Not applicable.

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?**

    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. (See Section III, Diagnosis and Trauma Code Edits, Paragraph 3).

C. <u>State Motor Vehicle Accident Report Files</u>

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

   There is currently no DMV match, although if an auto accident were identified via a Trauma Lead Letter (**Attachment "E"**), the IME Revenue Collections Unit would review the Trauma Lead Letter and create a lien case to pursue recovery.

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

   N/A

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

   N/A

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

   All Trauma Lead Letters indicating liability insurance, and/or an attorney are used for verification, notification and subrogation. A recovery file is opened for any members who indicate third party liability or attorney involvement. If the member indicates on the Trauma Lead Letter that there is no insurance or legal action, the IME Revenue Collections Unit evaluates the case to determine need for further investigation. Examples of the types of considerations made by the IME Revenue Collections Unit include circumstances of the accident as related in the Trauma Lead Letter and total Medicaid dollars spent. Types of expanded investigation which may be done include contacting the property or automobile owner, providers, DHS caseworkers, 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 Trauma Lead Letters indicating liability insurance, and/or an attorney are used for verification, notification and subrogation. A recovery file is opened for any members who indicate third party liability or attorney involvement. If the member indicates that there is no insurance or legal action, the IME Revenue Collections Unit evaluates the case to determine need for further investigation. Examples of the types of considerations made by the IME Revenue Collections Unit include circumstances of the accident as related in the questionnaire and total Medicaid dollars spent. Types of expanded investigation which may be done include contacting the property or automobile owner, providers, DHS caseworkers, and/or attorneys directly.

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

Within forty-five (45) days of receipt of the information identified in Section I.A.3. the IME Revenue Collections Unit follows up on such information in order to identify legally liable third party resources and incorporates such information into the case management database.

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

Refer to Section I.A.6., Page 7.

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

Refer to Section I.A.7., Pages 7 and 8.

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

Refer to Section I.A.8., Page 9.

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

Within forty-five (45) days of receipt of the information identified in Section I.A.3., the contractor follows up on such information in order to identify legally liable third party resources and incorporates such information into the case management database.

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?

Refer to Section II.C. 1., Page 16.

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 Iowa Department of Human Services contracted with the IME Revenue Collections Unit to perform data matches in the following categories:

   a. Commercial Insurance Carriers, Pharmacy Benefit Managers, Third Party Administrators, Self-Funded Employer groups.
   b. Blue Cross/Blue Shield
   c. TriCare
   d. Medicare

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

   The contractor, IME Revenue Collections Unit, conducts the data matches.

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, including Medicare. 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 ten (10) business days of being verified. 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).**

   Refer to Section I.A.6., Page 7.

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

   Refer to Section I.A.7., Pages 7 and 8.

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

   Refer to Section I.A.8., Page 9.

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

    Within ten (10) business days from the receipt of verification, 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.**

   Yes - Diagnosis and trauma code edits are being conducted for all codes 800 through 999 with the exception of code 994.6.

   MMIS currently performs the Trauma Code Edits to identify appropriate claims to send questionnaires (Trauma Lead Letters). The IME Revenue Collections Unit is responsible for processing the returned questionnaires and creating lien cases when appropriate. The information is maintained in the case management system utilized by the IME Revenue Collections

Unit.

We have updated our processes to accommodate the ICD-10 coding as it relates to Trauma conditions.

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 Core Unit (contractor – Noridian) conducts the diagnosis and trauma code edits via the claims processing in the MMIS.

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 IME Core Unit. A questionnaire is sent to each member requesting verification as to the illness or injury. Upon receipt of member responses, the IME Revenue Collections Unit follows up and contacts liable third parties, initiates recovery action and tracks all efforts.

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

   Top priority is given to identifying possible third party liability for those members who have had at least $250.00 in trauma related claims during the month. Those individuals with less than $250.00 in claims are worked as time permits.

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 IME Revenue Collections Unit opens a subrogation case and files a lien.

   If the member indicates that there is no insurance or legal action pending, the IME Revenue Collections Unit evaluates the case to determine need for further investigation. Examples of the types of considerations made by the IME Revenue Collections Unit include circumstances of the accident related in the questionnaire and total Medicaid dollars spent. The expanded investigation, if pursued, could include contacting the owner of property where the trauma incident occurred or, if it is a motor vehicle accident, the insurance carrier for the owner of the automobile involved in the accident.

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., the IME Revenue Collections Unit follows up on the information in order to identify legally liable third party resources and incorporates the information into the TPL Subsystem of the MMIS.

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 for the third party determined to be liable for Medicaid claims identified as being trauma related, is maintained in a separate case management 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.

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 one (1) business day into the case management database. This information is then passed electronically and loaded to the claims subsystem of the MMIS.

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 preventive pediatrics, prenatal care 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 ELVS system and the TPL information that is maintained on the MMIS is included in the automatated response message.

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

   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) (see **Attachment "H"**) 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, per the TPL matrix, the claim is paid at the Medicaid allowed amount. If the claim is for pediatric or prenatal services, or the policyholder is a non-custodial parent, the claim is paid and then billed to the insurance carrier by the IME Revenue Collections Unit. When a claim is denied because TPL was not billed, it is reported on the remittance advice sent to the provider.

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 Medicaid claim that is received indicating a third party payment must include the amount of the third party payment and the provider's usual and customary charge for the service. The claim is priced, based on Medicaid allowable amount, and the TPL payment is subtracted. If the TPL amount is less than the Medicaid allowed amount, the balance of the claim is paid up to the Medicaid allowed amount. In order for providers to enroll in Iowa Medicaid, they must sign the Provider Enrollment Agreement that specifies that the providers are not to bill Medicaid for any claim amount that is paid by other insurance.

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

The MMIS tracks the cost avoidance dollars on the following reports: the IAMM4200-R002 Medicare Participation Analysis; the IAMT1200-R002 TPL Cost Avoidance Summary; and the IAMT1200-R003 TPL Cost Avoidance Summary by Coverage.

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

The MMIS produces the IAMT1200-R002 Cost Avoidance Summary by Coverage Report that includes information on the number of claims submitted that deny because of other insurance listed on members' records. The final paid amount after TPL payments is posted to the MMIS.

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?**

Iowa accounts for claims denied for cost avoidance purposes only up to the Medicaid payment limit.

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

Yes, we include Medicare. (See Answer to Section IV.6. above.)

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

Co-payments are tracked separately and are not included in the figure quoted on the 64.9a as cost avoided dollars.

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

Iowa includes estimated savings from third party insurance payments under other cost avoidance.

B. <u>Pay and Chase Recovery</u>

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 preventive pediatric, prenatal and IV-D enforceable claims, which are required to be paid and chased.

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).**

All claims for members with TPL are cost avoided except for preventive pediatric, prenatal and IV-D enforceable claims, which are required to be paid and chased.

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 threshold is set at $100.00. Casualty claims threshold is set at $250.00.

For casualty claims, the IME Revenue Collections Unit proactively prioritize cases with higher claim values, but reactively work any and all cases where an attorney or insurance company contacts us to request claim recovery information.

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

period of time?

The health insurance threshold is based on individual claims, not accumulated billings. Casualty and trauma claims are accumulated from the date of the accident and are added together for one (1) year to compare to the $250.00 threshold.

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

Within forty-five (45) business days of receipt of the claims information identified in Section I.A.3., the IME Revenue Collections Unit follows up on such information in order to identify legally liable third party resources and incorporates such information into the case management database.

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

Health insurance recovery is created by two sources: pay and chase claims and retroactive insurance coverage. The IME Revenue Collections Unit performs the billing for both of these sources. Retroactive insurance coverage occurs when Medicaid learns of the insurance after claims have already been paid. Pay and chase claims are identified for billing by the IME Revenue Collections Unit using codes that apply to the pay and chase services. The claims are passed through a matrix to determine which claims should be payable by a third party.

Each month, The IME Revenue Collections Unit receives a paid claims file of all claims paid by Medicaid for the prior month. The IME Revenue Collections Unit performs a data match between its national insurance database and the current Medicaid eligibility file and also uses the TPL Resource File from the TPL subsystem of the MMIS to pull in all possible sources of other insurance. The IME Revenue Collections Unit uses all the potential insurance information to bill all claims to liable third parties, including retroactive claims going back three (3) years and all pay and chase claims. The IME Revenue Collections Unit follows up on the high dollar and large volume of claims that have been denied or unprocessed by insurance carriers within sixty **(90)** business days. The IME Revenue Collections Unit contacts insurance carriers requesting a status on unpaid billings. If necessary, the claims will be rebilled to the insurance carrier and follow up will be conducted until claims are processed or denied.

Casualty or liability recoveries are initiated by many sources. Referrals are received from members, questionnaires (trauma), data matches, providers, attorneys and many other sources. When a casualty/liability case is discovered, the parties are notified of Medicaid’s subrogation and lien rights in writing. A claims summary printout is obtained from the MMIS system. Claims paid by Medicaid are reviewed and the claims determined

to be related to the casualty/liability case are calculated. The Revenue Collections Unit files a lien for the amount of related paid claims with the County Court where the member resides. Updated liens are filed as necessary to ensure Medicaid's lien is current**. Effective July 1, 2011, IME Revenue Collections Unit may initiate recovery on Medical Malpractice Claims.**

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

The IME Revenue Collections Unit utilizes all codes including HCPCS, diagnosis codes and revenue codes to mirror providers' claims received from the monthly provider claim file delivered by the IME Core Unit.

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

The IME Revenue Collections Unit receives eligibility from insurance carriers and compares Medicaid eligibility and claim data received from the IME Core Unit and compares the information for the claim date of service to determine if TPL is applicable. Once it is established that TPL exists, claims are billed accordingly. The IME Revenue Collections Unit applies edits to exclude typical non-reimbursable claims, such as long-term care nursing facility claims.

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

In the discovery phase of trauma investigation members with $250 or more in trauma related claims in one month are investigated first.

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

Casualty claims are recovered from all sources when the total reimbursable amount exceeds the priority level in Section IV.B.3. All recoveries are pursued equally.

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

The IME Revenue Collections Unit applies multiple follow-up procedures including rebilling, contacting third parties, and

targeting claims with high likelihood of recovery for aggressive follow up.

The IME Revenue Collections Unit provides the IME Core Unit vendor with electronic information on recovered claims for posting to the MMIS and pharmacy claims system. The IME Revenue Collections Unit submits recovery reports monthly to DHS that reconcile to the bank deposits.

The IME Revenue Collections Unit reviews billed claims weekly monitoring for high dollar claims and large volume of claims that are denied. The IME Revenue Collections Unit posts all billed claims to its accounts receivable system at the claim level and posts payments and denials received via batch posting electronically when possible or manually. The IME Revenue Collections Unit then creates a posting file used to adjust the claims history in the MMIS.

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 sixty **(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.

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

All recoveries are deposited into the Title 19 Recovery bank account.

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

All collections are posted back to the original claim in the form of an adjustment.

The IME Revenue Collections Unit Auditor reviews a 3% random selection of the daily work for each Posting Specialist. The Auditor will then review the selected adjustments to check for errors. If errors are found, the Auditor will fill out an adjustment correction sheet for the Posting Specialist to review and make necessary corrections.

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

Casualty case recoveries are calculated in accordance with Iowa Code 249A.6(4). (See **Attachment "J"** - the Iowa Medicaid Recovery Worksheet).

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).**

The IME Revenue Collections Unit maintains data exchange agreements and billing arrangements with multiple third parties. The terms of these agreements/arrangements vary significantly. (See **Attachment "K"** - Data Use Agreement Obtained by Medicaid that lists names of insurance carriers with which Health Management Systems and the Department of Human Services has data use agreements).

The IME Revenue Collections Unit follows up on the high dollar and large volume of claims that have been denied or unprocessed by the carrier within sixty **(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 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 IME Revenue Collections Unit monitors yield by following up on the high dollar and large volume of claims that have been

denied or unprocessed by the carrier within sixty **(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.

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.**

   Yes - see HIPP Documentation (**Attachment "L"**).

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 IME Revenue Collections Unit pursues 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 Medicaid 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.

   Effective July 1, 2011 The IME has Revenue Collections unit pursues Special Needs Trusts as part of the third party liability collections function. The approach utilized is five – fold:

A) To ensure the all applications for Special needs trusts are accurately filed in accordance with the legislation
B) To ensure that all monies spent within the trust are for the benefit of the effected member and are appropriate expenditures.
C) All existing trusts are reviewed at least annually whether or not a request for expenditure has been made by the Trustee.
D) Active communication with the trustee, normally written, is a part of this process. The goal is to serve in partnership with the trustee while ensuring the Special Needs Trusts Rules are upheld.
E) Appropriate reporting is provided to the State for tracking of this program.

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 other contractors are used

Attachment A - Insurance Questionnaire (Form 470-2826)

Iowa Department of Human Services

Insurance Questionnaire

To ensure that your bills are paid as quickly as possible, please fill out this form and return to your local Department of Human Services (DHS) office.

Your Name: ______________________ Your State ID number, if any: ________________

Do you, your children or others in your home have health insurance coverage? ☐ Yes ☐ No, then stop here.

If yes, who carries this health insurance?

☐ You ☐ A parent who does not live with you

☐ Someone else in your home ☐ Someone else not in your home

Please fill out the information below. The boxes with this mark * must be filled in. Use the next page if you have another policy to tell us about.

Information About First Policy

Choose **all** that apply to this policy:

☐ Major Medical ☐ Drug ☐ Medicare Supplement

☐ Dental ☐ Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number ( )
Mailing address (House #, Street, Apt, *OR* PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number ( )
Insurance claims office mailing address (#, Street, *OR* PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One: Add	Drop	Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Information About Second Policy

Choose **all** that apply to this policy:

- ☐ Major Medical
- ☐ Dental
- ☐ Drug
- ☐ Vision
- ☐ Medicare Supplement

*Policyholder (Last Name, First Name, Middle Initial)		Phone number ( )
Mailing address (House #, Street, Apt, *OR* PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #

*Insurance company name		Phone number ( )
Insurance claims office mailing address (#, Street, *OR* PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One: Add	Drop	Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Is there anything else about the insurance information you gave that you want to tell about? If yes, please use this space.

____

____

____

____

For office use only:
County # ____________
Worker # ____________
Date Rec'd ____________

Attachment B - Trauma Leads Report - IAMT1600-R001

IAMT1600-R001 IOWA DEPARTMENT OF HUMAN SERVICES
PAGE 1
AS OF 05/31/07 MEDICAID MANAGEMENT INFORMATION SYSTEM
RUN DATE 05/26/07

T P L P R I O R I T Y T R A U M A L E A D S R E P O R T

RECIPIENT LAST FIRST STREET ZIP PROG
DATE OF DIAG
ID NAME NAME MI ADDRESS CITY STATE CODE
CODE DEAD SERVICE CODE

9999999D MOUSE MINNIE --- SHADY CT. CENTERVILLE IA 52544
640 N 050107 883.0
050107 923.3
052107 846.0
043007 883.0
043007 883.0
043007 E918

PROVIDER STREET ZIP PROV AMOUNT OF
AMOUNT OF
DESCRIPTION NAME ADDRESS CITY STATE CODE TYPE
CHARGES PAYMENTS

OPEN WOUND OF FING PONCY, PAUL D DO CENTERVILLE FAMILY
CENTERVILLE IA 52544 03 73.00 44.61
CONTUSION OF FINGE 73.00
44.61
LUMBOSACRAL (JOINT 50.00
32.36
OPEN WOUND OF FING MERCY MEDICAL CENT CENTERVILLE IA
52544 02 176.00 113.21
OPEN WOUND OF FING 157.00
61.01
CAUGHT BETWEEN OBJ ST JOSEPHS MERCY H RR 2 CENTERVILLE IA
52544 01 481.64 201.24 TOTAL CHARGES 1010.64

TOTAL PAID 497.04

Attachment C - TPL Leads Report – IAMT1600-R006

IAMT1600-R006 IOWA DEPARTMENT OF HUMAN SERVICES PAGE 1
AS OF 06/30/07 MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE 06/23/07

T P L L E A D S R E P O R T

RECIPENT NAME		DATE OF BIRTH	RECIP ID	CTY	PROVIDER NAME	PROV NUM	DATE OF SERVICE	AMOUNT PAID	TCN
MOUSE	MICKEY	03/16/07	9999999E	88	CRESTON MEDICAL CLINIC	P 0013532	03/16/07	6.78	00714922016036300
MOUSE	MICKEY	03/16/07	9999999E	88	CRESTON MEDICAL CLINIC	P 0013532	03/17/07	20.79	00714922016036200
MOUSE	JAMIE	03/24/88	9999999A	57	ST LUKES METHODIST HOSP	0600452	03/07/07	1,730.37	00716511032005500
MOUSE	JAMIE	09/22/05	9999999A	77	MERCY PEDIATRIC CLINIC	0236174	04/10/07	0.00	00716422015019600
MOUSE	MINNIE	09/22/05	9999999A	77	MERCY PEDIATRIC CLINIC	0236174	04/10/07	0.00	00716422015019600

Attachment D - Other Insurance Request (Form 470-0403)

Iowa Department of Human Services

Other Insurance Request

<<NAME>> <<ADDRESS>> <<ADDRESS>> <<CITY>>, <<STATE>> <<ZIPCODE>>	<<Date>> Reference Number: <<<<<>>>>>

Iowa Medicaid has information that <<First Name Last Name>> has other insurance. The form on the back of this letter must be completed to see if other insurance should pay a claim before Medicaid. A parent or legal guardian should complete and sign the form for a child under the age of 18.

To complete the form over the phone, between 8:00 a.m. and 5:00 p.m., call the Iowa Medicaid Member Services Unit at 1-800-338-8366, or in the Des Moines area 515-256-4606. To better assist you, please have the above reference number ready when you call.

Please provide the insurance information by: <<DueDate>>.

If you prefer to return a written copy of the form, use one of the options below:

Email:	Revcol@dhs.state.ia.us
Fax:	515-725-1352
Mail:	Iowa Medicaid Enterprise
	Revenue Collections P.O. Box 36475 Des Moines, IA 50315-9930

Para solicitar este documento en español, comuníquese con Servicios a los Miembros al teléfono 1-800-388-8366, de lunes a viernes desde las 8:00 a.m. hasta las 5:00 p.m.

Complete this form and return it by <<DueDate>>:

The information requested on this form is about: <<First Name Last Name>>

Medicaid #: <<Medicaid ID>> | Reference Number: <<<<<>>>>>

Medical coverage ☐Yes ☐No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Prescription coverage ☐Yes ☐No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Dental coverage ☐Yes ☐No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Vison coverage ☐Yes ☐No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Is there anyone else in the family that is covered by the same policies? ☐Yes ☐No

If yes, provide their Medicaid #, name, and mark all the policies they have.

Medicaid #	First and Last Name	Medical	Rx	Dental	Vision

Sign, date, and return the completed form using the instructions on the front side.

Signature	Date
Print name	Relationship to <<firstname>>
Home Phone Number	Cell Phone Number

470-0403 (Rev. 02/15)

Attachment E - Accident Injury Request (Form 470-0398)

Iowa Department of Human Services

Accident Injury Request

<<NAME>>
<<ADDRESS>>
<<ADDRESS>>
<<CITY>>, <<STATE>> <<ZIPCODE>>

<<Date>>

Reference Number: <<<<<>>>

Important Notice: If this form is not completed in writing or over the phone, Medicaid benefits *may* be canceled.

<<First Name Last Name>> received treatment for an accident or injury. The information on the back of this form must be completed to see if somebody else should have paid for the treatment

A parent or legal guardian should complete and sign the form for a child under the age of 18, or call Iowa Medicaid Member Services at 1-800-338-8366 to complete the information over the phone. Iowa Medicaid Member Services will need the reference number. Please return the form using one of the following ways by <<DueDate>>.

Email: RevCoLLLien@dhs.state.ia.us

Fax: 515-725-1352

Mail: Iowa Medicaid Enterprise
Revenue Collections
P.O. Box 36446
Des Moines, IA 50315

Phone: Member Services
1-800-338-8366
or locally in the Des Moines area at **515-256-4606**
Monday through Friday, 8:00 am to 5:00 pm

Para solicitar este documento en español, comuníquese con Servicios a los Miembros al teléfono 1-800-388-8366, de lunes a viernes desde las 8:00 a.m. hasta las 5:00 p.m.

Complete Accident Injury Request form and return it by <<DueDate>>:
If this form is not completed in writing or over the phone,
Medicaid benefits *may* be canceled.

<<First Name Last Name>>, <<Medicaid ID>>

Date of Treatment: <<date of service>> Reference Number: <<<<<>>>>>
Provider's Name: <<Provider's name>>

Was the treatment a result of an accident or injury? ☐ Yes ☐ No
If no, sign and date this form. See the front page on how to return the form.

If yes, did the accident or injury happen on <<Date of service>>? ☐ Yes ☐ No
If no, please tell us the correct date of the accident or injury. ____/____/______
(mm/dd/yyyy)

Tell us what happened and what the injuries were. If more space is needed, attach a separate sheet of paper.

____
____
____
____
____
____

Has a lawyer been hired? ☐ Yes ☐ No If yes, complete this section.

Name of Lawyer		Phone Number
Address		
City	State	ZIP Code

Was a claim filed with an insurance company? ☐ Yes ☐ No If yes, complete this section.

Insurance Company Name		Contact Name
Address		
City	State	ZIP Code
Phone Number	Claim Number	
Policy Holder Name	Policy Number	

Sign, date, and return the completed form using the instructions on the front side.

Signature	Date
Print name	Relationship to member
Home Phone Number	Cell Phone Number

470-0398 (Rev. 02/15)

Attachment F - MMIS TPL Resource Display Record

```
06/22/07              TPL RESOURCE DISPLAY SCREEN               INQUIRY
             RECIP ID: 999999G     SSN: 000000000   SEX: X
NAME: MOUSE           MINNIE               BIRTH: 0101 1980   DEATH:
 PGM: 37E               COUNTY: 57   LAST-TRANS: 110106      USER: 999
 --------------------------- THIRD PARTY LIABILITY ---------------------------
   01    VER-IND: 2 VERIFIED Y  DT-ADD: 110106  ONL-UPD: 110106   USER: 999
 DATE-POL-VERIFIED: 110106   1ST-CORRES-SENT:        BATCH-UPDATED: 110106
 POL-NUM: 999999999                  CARRIER: H02679       RETRO:
 COV-BEGIN: 040106   COV-END: 102506        PRINCIPAL
 COVER-TYPE: 06 19          RELATION: 3
 HIPP:       POL-TYPE: G  CASE:
 POLICY HOLDER   SSN: 999999999            PO BOX 99999
     NAME: MOUSE, MICKEY                   COLORADO SPRINGS  CO  809499710
                            (800) 999-9999
 GROUP NUMBER:                AB PARENT:     AB PARENT SSN:
 H34043-1                  AB PARENT NAME:
 GROUP NAME && ADDRESS                   ABSENT PARENT ADDRESS:



   COMMENTS: AUTOMATED UPDATE 11/01/06
```

IOWA MEDICAID GUIDE

TYPE OF HEALTH INSURANCE CODES FROM RECIPIENT ID CARD

3RD BYTE POSITION - PRIVATE INSURANCE

A HOSPITAL
B PHYSICIAN
C DENTAL
D DRUGS
E HOSPITAL/PHYSICIAN
F HOSPITAL/PHYSICIAN/DENTAL
G HOSPITAL/PHYSICIAN/DENTAL/DRUG
H HOSPITAL/DENTAL
I HOSPITAL/DRUG
J HOSPITAL/PHYSICIAN/DRUG
K PHYSICIAN/DRUG
L PHYSICIAN/DENTAL
M HOSPITAL/PHYSICIAN/DENTAL/DRUG/VISION
N HOSPITAL/PHYSICIAN/DRUG/VISION
O HOSPITAL/PHYSICIAN/VISION
P HOSPITAL/PHYSICIAN/OTHER
Q HOSPITAL/PHYSICIAN/DENTAL/OTHER
R HOSPITAL/PHYSICIAN/DENTAL/DRUG/OTHER
S HOSPITAL/DENTAL/OTHER
T HOSPITAL/DRUG/OTHER
U HOSPITAL/PHYSICIAN/DRUG/OTHER
V VISION
W PHYSICIAN/DRUG/OTHER
X OTHER
(INCLUDING AMBULANCE, HOME HEALTH, HOSPICE, LAB/XRAY, MEDICAL EQUIPMENT, SNF, INF, SPECIFIC DISEASE - HEART & CANCER & ANY OTHER TYPE.
Y PHYSICIAN/DENTAL/OTHER
Z HOSPITAL/PHYSICIAN/DENTAL/DRUG/VISION/OTHER
0 (ZERO) NONE
1 HOSPITAL/PHYSICIAN/DRUG/VISION/OTHER
2 HOSPITAL/PHYSICIAN/VISION/OTHER

4TH POSITION - OTHER RESOURCE CODE

A MEDICARE PART A
B ACCIDENT
G ABSENT PARENT, NON-COURT ORDERED
H ABSENT PARENT, COURT ORDERED
I MAJOR MEDICAL
J ABSENT PARENT, MAJOR MED, NON-COURT ORDERED
K ABSENT PARENT, MAJOR MED, COURT ORDERED
L INDEMNITY
0 NONE
1 MEDICARE PART B
2 MEDICARE PART A & B
3 CHAMP AND VA
4 CHAMPUS
5 VETERANS ADMINISTRATION
6 OTHER
7 CHAMPUS, ABSENT PARENT, NON-COURT ORDERED
8 CHAMPUS, ABSENT PARENT, COURT ORDERED
9 MEDICAID TRUST

TPL COVERAGE TYPES

01 BASIC HOSPITAL
02 BASIC MEDICAL
05 HOSPITAL INDEMNITY
06 MAJOR MEDICAL
07 ACCIDENT ONLY
12 MEDICARE SUPPLEMENT
13 NURSING HOME SUPPLEMENT
15 DENTAL
16 CHAMPUS
17 MEDICAID TRUST
18 VETERANS ADMINISTRATOR
19 PHARMACY
20 VISION
23 PART A
24 PART B
25 CASUALTY
99 PSEUDO

Attachment H -TPL Matrix

TPL Matrix

T P L   C O V E R A G E   T Y P E (EX0701)

Legend: "3"=Exception 263 Posts - Pay ; "4"=Exception 264 Posts - Pay and Post;
"5"= Exception 265 Posts - Deny; "I"=For Accident Diag Codes (800-999),Post 265 otherwise 263.

		Basic Hospital	Basic Medical/Phy	Hospital Indemnity	Major Medical	Accident Only (Non-Auto)	Mcare Supplement	Nursing Home	Dental	Tricare	Veterans Admin	Drugs	Vision	Casualty
Prov	**Description**	**01**	**02**	**05**	**06**	**07**	**12**	**13**	**15**	**16**	**18**	**19**	**20**	**25**
1	General Hospital	265	263	265	265	263	265	263	263	265	265	263	263	264
2	Physician MD	263	265	263	265	263	265	263	263	265	265	263	265***	264
3	Physician DO	263	265	263	265	263	265	263	263	265	265	263	265***	264
4	Dentist	263	263	263	263	263	263	263	265	265	263	263	263	264
5	Podiatrist	263	265	263	265	263	265	263	263	265	265	263	263	264
6	Optometrist	263	263	263	263	263	265	263	263	265	265	263	265	264
7	Optician	263	263	263	263	263	263	263	263	265	263	263	265	264
8	Pharmacy	263	265	263	265	263	265	263	263	265	265	*	263	264
9	Home Health Agency	263	265	263	265	263	265	263	263	265	265	263	263	264
10	Independent Lab	265	265	263	265	263	265	263	263	265	265	263	263	264
11	Ambulance	265	265	263	265	263	265	263	263	265	265	263	263	264
12	Medical Supplies	263	265	263	265	263	265	263	263	265	265	263	263	264
13	Rural Health Clinic	263	265	263	265	263	265	263	263	265	265	263	263	264
14	Clinic	263	265	263	265	263	265	263	263	265	265	263	263	264
15	Physical Therapist	263	265	263	265	263	265	263	263	265	265	263	263	264
16	Chiropractor	263	265	263	265	263	265	263	263	265	265	263	263	264
17	Audiologist	263	265	263	265	263	265	263	263	265	265	263	263	264
18	Skilled Nursing Facility	263	263	263	263	263	265	265	263	265	265	263	263	264
19	Rehab Agency	265	265	263	265	263	265	263	263	265	265	263	263	264
20	Intermediate Care Facility	263	263	263	263	263	263	265	263	263	265	263	263	264
21	Community Ment Hlth	263	265	263	265	263	265	263	263	265	265	263	263	264
22	Family Planning	263	265	263	265	263	263	265	263	265	265	263	263	264
23	Residential Care Facility	263	263	263	263	263	263	265	263	263	265	263	263	264
24	HMO	263	263	263	263	263	263	263	263	263	263	263	263	263
25	ICF MR State	263	263	263	263	263	263	265	263	263	265	263	263	264
26	Mental Hospital	265	263	265	265	263	265	263	263	265	265	265	263	264
27	Comm Based ICF/MR	263	263	263	263	263	263	265	263	263	265	263	263	264
		Basic Hospital	Basic Medical/Phy	Hospital Indemnity	Major Medical	Accident Only (Non-Auto)	Mcare Supplement	Nursing Home	Dental	Tricare	Veterans Admin	Drugs	Vision	Casualty
Prov	**Description**	**01**	**02**	**05**	**06**	**07**	**12**	**13**	**15**	**16**	**18**	**19**	**20**	**25**
29	Psychologist	263	265	263	265	263	265	263	263	265	265	263	263	264
30	Screening Center	264	264	263	264	264	264	263	263	264	264	263	263	264
31	Hearing Aid Dealer	263	265	263	265	263	263	263	263	265	265	263	263	263

32	Occupational Therapist	263	265	263	265	263	265	263	263	265	265	263	263	264
33	Tape Intermediary	263	263	263	263	263	263	263	263	263	263	263	263	263
34	Orthopedic Shoe Dealer	263	265	263	265	263	265	263	263	265	265	263	263	264
35	Maternal Health Center	263	263	263	263	263	263	263	263	263	263	263	263	264
36	Ambulatory Surg Center	265	265	263	265	263	265	263	263	265	265	263	263	264
37	Genetic Counselor	263	263	263	263	263	263	263	263	263	263	263	263	264
38	Certified Nurse Midwife	263	265	263	265	263	263	263	263	265	265	263	263	264
39	Birthing Center	265	263	263	265	263	263	263	263	265	265	263	263	264
40	AEA	263	263	263	263	263	263	263	263	263	263	263	263	264
41	Psych Medical Inst Child	265	265	265	265	263	265	263	263	265	265	263	263	264
42	MEP Case Manager	263	263	263	263	263	263	263	263	263	263	263	263	264
44	CRNA	263	265	263	265	263	265	263	263	265	265	263	263	264
45	Hospice	265	263	263	265	263	265	263	263	265	265	263	263	264
46	Prepaid Health Plan	263	263	263	263	263	263	263	263	263	263	263	263	263
47	HIPP	263	263	263	263	263	263	263	263	263	263	263	263	263
48	Clinical Social Worker	263	265	263	265	263	265	263	263	265	265	263	263	264
49	Fed Qual Health Center	263	265**	263	265**	263	265**	263	265**	265	265**	263	263	264
50	Nurse Practitioner	263	265	263	265	263	265	263	263	265	265	263	263	264
52	Nursing Facility -Ment Ill	263	263	263	263	263	263	265	263	263	265	263	263	264
53	Ment Hlth Subst Abuse Pl	263	263	263	263	263	263	263	263	263	263	263	263	263
54	County Relief	263	263	263	263	263	263	263	263	263	263	263	263	263
55	Lead Investigagion	263	263	263	263	263	263	263	263	263	263	263	263	263
56	LEA	264	264	264	264	264	264	264	264	264	264	264	264	264
57	Infant Toddler Providers	264	264	264	264	264	264	264	264	264	264	264	264	264
58	PACE	263	263	263	263	263	263	263	263	263	263	263	263	263
59	Indian Health Service	264	264	264	264	264	264	264	264	264	264	264	264	264
60	Institutional General	264	264	264	264	264	264	264	264	264	264	264	264	264
61	Other Practitioner	264	264	264	264	264	264	264	264	264	264	264	264	264
62	Behavioral Health Service	263	265	263	265	263	265	263	263	265	265	263	263	264
63	Remedial	264	264	264	264	264	264	264	264	264	264	264	264	264
64	Habilitation Services	263	263	263	263	263	263	263	263	263	263	263	263	263
83	Medically Needy Only	263	263	263	263	263	263	263	263	263	263	263	263	263
86	Non Provider Mail Only	263	263	263	263	263	263	263	263	263	263	263	263	263
97	RCF Guardian	263	263	263	263	263	263	263	263	263	263	263	263	263
98	Lienholder	263	263	263	263	263	263	263	263	263	263	263	263	263
99	Waiver	263	263	263	263	263	263	263	263	263	263	263	263	264

*Editing done on POS system

** For provider type 49, if provider bills on CMS-1500 for medical services code T1015 on line 1 with supporting codes on additional lines for 06 coverage, 265 edit will post; for 15 coverage edit 263 will post. If provider bills on Dental claim form for dental services code D9999 on line 1 with supporting dental codes on additional lines for 02, 06, 12, and 18 coverage edit 263 will post; for 15 and 16 coverage edit 265 will post.

Attachment I - Centralized Employee Registry Reporting Form (Form 44-019)

Centralized Employee Registry Reporting Form

TO BE COMPLETED BY THE EMPLOYER within 15 days of hire. Please Print or Type

Mail this portion of the page to Centralized Employee Registry, PO Box 10322, Des Moines IA 50306-0322; or fax it to 1-800-759-5881. You may also submit the information online at www.iowachildsupport.gov

EMPLOYER INFORMATION

Phone: Area Code + Telephone Number (____) ____ - ____

FEIN plus last 3-digit suffix as shown on your Iowa label or return. ___-_______-___

Name: ____

Street Address: ____

City: ____ State: ____ Zip Code: _____-____

Questions: For A through D below, please see instructions on back for definitions and clarification.

A. Is dependent health care available? Yes ☐ or No ☐

B. Approximate date this employee qualifies for coverage: MM DD YYYY

C. Employee start date: MM DD YYYY

D. Address where income withholding and garnishment orders should be sent, if different than above address.

Street Address: ____

City: ____ State: ____ Zip Code: _____-____

EMPLOYEE INFORMATION

Employee's Date of Birth: MM DD YYYY Employee's Social Security Number: ___-__-____

Last Name: ____ First Name: ____ Middle Initial: ____

Street Address: ____

City: ____ State: ____ Zip Code: ____

Iowa Department of Revenue
www.state.ia.us/tax

IA W4 2007

Employee Withholding Allowance Certificate

Employers: Detach this part and keep in your records unless more than 22 withholding allowances are claimed. See Employer Withholding Requirements on the back of this form.

To be completed by the employee.

EMPLOYEE ONLY

Marital status: ☐ Single ☐ Married (If married but legally separated, check Single.)

Print your full name: ____ Social Security No.: ____

Home Address (No. and St. or RR) ____ City ____ State ____ Zip Code ____

EXEMPTION FROM WITHHOLDING. If you do not expect to owe any Iowa income tax this year, and expect to have a right to a full refund of ALL income tax withheld, enter "EXEMPT" here: ____ and the year effective here: ____ **Nonresidents may not claim exemption.**

If you are not exempt, complete the following:

1. Personal allowances .... 1. ____
2. Allowances for dependents .... 2. ____
3. Allowances for itemized deductions .... 3. ____
4. Allowances for child and dependent care credit .... 4. ____
5. Total allowances. Add lines 1 through 4. .... 5. ____
6. Additional amount, if any, you want deducted each pay period .... 6. ____

I certify that I am entitled to the number of withholding allowances claimed on this certificate, or if claiming an exemption from withholding, that I am entitled to claim the exempt status.

Employee Signature ____ **Date** ____

Employer: Complete below only if you are sending this part to the Iowa Department of Revenue because the employee is claiming more than 22 total allowances.

Employer's name and address ____ FEIN ____

44-019a (7/26/06)

Attachment J - Iowa Medicaid Recovery Worksheet

IOWA MEDICAID RECOVERY WORKSHEET

TOTAL SETTLEMENT AMOUNT	________________________
DEDUCT ATTORNEY FEE	________________________
DEDUCT DOCKETED COURT COSTS	________________________
BALANCE REMAINING	________________________

Divide the balance remaining by 3

1/3 BALANCE PAID TO RECIPIENT*	________________________
2/3 BALANCE SUBJECT TO MEDICAID LIEN	________________________

**Any non-docketed court costs (i.e. copies, depos., etc.) or any advanced expenses would come from these funds.*

EXAMPLE CALCULATIONS:

TOTAL SETTLEMENT AMOUNT	$10,000.00	$10,000.00
LESS ATTORNEY FEE	$ 3,334.00	$ 3,334.00
LESS DOCKETED COSTS	$ 150.00	$ 150.00
BALANCE REMAINING	$ 6,516.00	$ 6,516.00
(divide by 3)		
1/3 BALANCE TO RECIPIENT	$ 2,172.00*	$ 2,172.00
2/3 BALANCE SUBJECT TO LIEN	$ 4,344.00	$ 4,344.00
HYPOTHETICAL MEDICAID LIEN	$ 2,000.00	$ 5,000.00
ADDITIONAL PAYMENT TO RECIP.	$ 2,344.00	$ 0.00
TOTAL AMOUNT TO MEDICAID	$ 2,000.00	$ 4,344.00**

***If the lien amount is greater than the 2/3 balance subject to the lien, Medicaid will accept the lesser of the two amounts (i.e. whatever the 2/3 balance is).*

Refer to IOWA CODE 249A.6 (4)

Attachment K - Iowa Medicaid Data Use Agreements

IOWA MEDICAID DATA USE AGREEMENT

Insurance Company	Contact Name	Title	Street Address	Phone Number/Email
Aetna	Maureen Weldon	Regional Compliance Director	100 N. Riverside Plaza, 18th Floor Chicago, Il 60606	(312) 928-3156 WeldonM@aetna.com
American Medical Security Life Ins.	Nikki Winkler	Sr. Compliance Corporate Project Leader	3100 Ams Blvd. Green Bay, WI 54313	(920) 661-1111 extension12270 Nikki.Winkler@eams.com
American Republic	DeeDee Birsall	AVP-Compliance	601 6th Ave. Des Moines IA. 50334	(515) 245-2243
AXA Equitable Life	Bret Kolb	Assistant Vice President	210 S. White St. Lancaster, SC 29720	(803) 416-5765 Bret Kolb@axa-financial.com
Central Reserve Life	Mary Ellen Larkin	Sr. Vice President-Compliance	17800 Royalton Rd. Strongsville, Ohio 44136	(440) 572-8845 mlarkin@ceresmed.com
Continental General	Mary Ellen Larkin	Sr. Vice President-Compliance	17800 Royalton Rd. Strongsville, Ohio 44136	(440) 572-8845 mlarkin@ceresmed.com
Coventry Health Care	Deanna Gray	CFO	4600 Westown Parkway, Suite 200 West Des Moines, IA. 50266	(515) 225-1234 extension 3163
Delta Dental	Lois Crilly	VP, Operations	2301 S.E. Tones Dr. Suite 13 Ankeny, IA. 50021	(515) 261 - 5552 lcrilly@deltadentalia.com
Health Alliance Midwest Inc.	Monica Zachary	Director of Compliance	102 East Main St. Urbana, Il 61801	(217) 337-3497 monica.zachary@healthalliance.org
Medical Associates Health Plan	Jodi Millius	Compliance Coordinator	1605 Associates Drive, Suite 101 Dubuque, IA 52002	(563) 584-4836 jmillius@mahealthcare.com
Mony Life	Sharon Monroe	Manager, Disability and Medical Claims	Mony Plaza PO Box 4815 Syracuse, NY 13221	(315) 447-2372 smonroe@mony.com
Pekin Life	Gary L. Heriford	Programmer Manager	2505 Court St. Pekin, IL 61558	(309) 478-2395 gheriford@pekininsurance.com
Principal Life	Kathy Jacobson	Legislative Reporting Analyst	711 High Street Des Moines, IA 50392-0302	(515) 235-1005 jacobson.kathy@principal.com

IOWA MEDICAID DATA USE AGREEMENT

Insurance Company	Contact Name	Title	Street Address	Phone Number/Email
Provident American Life and health	Mary Ellen Larkin	Sr. Vice President-Compliance	17800 Royalton Rd. Strongsville, Ohio 44136	(440) 572-8845 melarkin@ceresmed.com
Prudential	Donna Grassano	Associate Manager-Systems	751 Broad Street Newark, NJ 07747	(973) 802-5463 donna.grassano@prudential.com
Sentry	David Smith	President	E.J. Smith & Associates, Inc 899 Skokie Blvd. Northbrook IL 60062	(847) 564-3660 www.ejsmith.com
State Farm	Tammy Grove	Analyst, Benefits & Services	One State Farm Plaza, C-1 Bloomington, IL 61710	(309) 766-0090 tammy.grove.hir0@statefarm.com
Trustmark Companies	Melissa E. Kerz	Asst. Vice President, Benefits	400 Field Dr. Lake Forest, IL 60045	(847) 283-2146 mkerz@trustmarkins.com
Unicare Life and Health	Judith Givens		233 S. Wacker Dr., Suite 3900 Chicago, IL 60606	(314) 923-7883 judith.givens@wellpoint.com
United Wisconsin	Kristine L. Schneider	Director, Client Services Operations	145 S. Pioneer Road Fond du Lac, WI 54936 - 2270	(920) 907-5762 kris.schneider@cobalt-corp.com
Wellmark Blue Cross Blue Shield	Rick Berg	Membership System Liason	636 Grand Ave. Des Moines, IA 50309	(515) 235-4109 bergr@wellmark.com
World Insurance	Gene Miller	Computer Operations Supervisor	11808 Grant St. Omaha, NE 68164-3603	(402) 496-8004 gmiller@worldinsco.com

Carrier/TPA/PBM

AARP
Administration Services
Advantage Health Solutions
Aetna/Aetna US Healthcare
Affinity Insurance Services
American Administrative Group
American Administrative Group/AAGCO/Gallagher
American Community
American Heritage
American Medical Security
American National Insurance
American Pioneer Life Ins. Co.
American Republic
Anthem KY
Anthem CO
Anthem CT
Anthem IN
Anthem ME
Anthem Midwest
Anthem MO
Anthem NH
Anthem OH (Community Insurance Co.)
Anthem VA
APWU
Arnett Health Plan
Assurant
Avera Health Plans
AVMED
Bankers Life & Casualty
BCAR
BCBS FL
BCBS GA
BCBS IL
BCBS IL
BCBS KC
BCBS KS
BCBS LA
Delta Dental IA
Delta Dental MA
Delta Dental MI / IN
Delta Dental Mid-Atlantic (includes DDIC)
DentaQuest, TPA of Delta Dental MA
Diversified Group Brokerage
Educator's Mutual
Elderplan
Employee Plans
Equitable Life
Excellus
Excellus (BCBSNY - Rochester)
Express Scripts
Federated Mutual
FEP
Fidelity Security Life (includes Forest T. Jones, Co.)
First Administrators
Florida Benefit Administrators
Florida Health Care Plan
Foundation Health
GEHA
Geisinger Health Plan
GHI
Golden Rule
Great West
Group & Pension Administrators
Guardian
Harvard Pilgrim
HCH Administration
Health First/Managed Health
HealthNet
Heart of America Health Plan
HIP of NY
Horizon BCBS NJ
Humana
Independent Health
IUOE #825
Principal
Prof Admin/Heritage Consultants
Professional Benefit Administrators
Providence Administrative Services
Prudential LTC
QCA Health Plan
Qual Choice Select (OH)
Regence BCBS Utah
RMHMS - Anthem West
RX Options
Sandford Health Plan (formerly Sioux Valley Health Plan)
Scott & White Health Plan
Seafarers Int'l Union
SEGBP
SEGBP (LAOGB)
Self Insured Benefit Administrators (SIBA)
SIHO
State Farm
Stewart C. Miller
SummaCare
SummaCare / Apex Benefit Svcs.
Teacher's Active/Retirement TX
Teacher's Retirement TX
TRICARE
Trustmark
Tufts Health Plan
Ullico
Unicare - Mass Mutual / Hancock
Unified Group Services
United American
United Group Program
United Healthcare
United Medical Resource
Univera Healthcare
Universal Care
UPMC
Vista Healthplan

BCBS MA
BCBS MT
BCBS NC
BCBS NE
BCBS NM
BCBS RI
BCBS Western NY (Healthnow)
BCCA - Wellpoint
Benefit Source
Benesight
Benesight (FISERV)
BeniComp Group
Blueshield CA
Boilermakers Nat'l Health & Welfare
Capitol Administrators
Carefirst BCBS MD
Catalyst RX
CBCA RX
CBSA
CCStpa
CDPHP
Celtic Insurance Company
Central Reserve
Central States
CIGNA
CIGNA (4)
CIGNA Behavior Health
CNA
Coastal TPA
Community First Health Plan
Community Managed Care
Connecticare
Cooperative Benefit Administrators
Coventry
Cox Health Plan
DakotaCare
Delta Dental CA, Mid-Atlantic, DDIC

JLT Services (acquired by Aegon)
John Hancock (LTC)
Keystone Health Plan West
Lovelace Health Plan
LTC Group
Mailhandlers
MDNY
Medical Associates Health Plan
Medical Mutual of OH
Medical Network
MEGA Life & Health
Mercy Health Plan
Meritain Health
Meritain Health (Century Planners/Westport Benefits)
Mid-West Life Insurance
Missouri Consolidated Health Care Plan
Mountain BCBS WV
M-Plan The Health Plan Group
Mutual Assurance Administrators
Mutual of Omaha
MVP Healthcare
NALC
National Benefit Administrators
Nationwide
Neighborhood Health Partnership
New England Financial / The New England
North Carolina Mutual Life
Oxford
Oxford Life
Pacificare
Paramount Health Care
Partners Rx Management
Pekin Insurance
Physician Health Plan of No. Indiana
Piedmont Administrators (MedCost)
Preferred Health Systems
Presbyterian Health Plan

Vytra Health Plans
Wakely Asc - representing 16 companies
Walgreens
Wal-Mart
Welborn
Wellchoice (via Empire)
WellChoice NJ
Wellmark Iowa
Wellmark South Dakota
Wellpoint (BCCA Unicare, JH, Mass Mutual)
Wells Fargo (formerly Accordia National)
Western Health Advantage

Attachment L - HIPP Documentation

THE COST EFFECTIVE FORMULA

When determining cost effectiveness of the insurance plan, the cost of buying the insurance is compared to the average cost to Medicaid to provide the same services covered by the plan:

Ave. TXIX Cost. for services covered Under the insurance policy (annual) - (Annual Premium Cost + Policy Deductible + Administrative) Cost = Savings/Loss

$50 per person annually

Determined by:

1. **Age:**
   - **0-60 days**
   - **61dys-5yrs**
   - **6-12 yrs**
   - **13-20 yrs**
   - **21-48 yrs**
   - **49-65 yrs**
   - **66-79 yrs**
   - **80+yrs**
2. **Sex**

Savings must = $5 per Month per household for a "buy" recommendation

May 29, 2007

SUMMARY OF STATE PLAN UNDER TXIX OF THE SOCIAL SECURITY ACT

1906 of the Act	State Method on Cost-Effectiveness of Employer-Based Group Health Plans

Iowa's Formula for determining cost-effectiveness of insurance plans that are not automatically determined cost-effective is as follows:

Savings from the plan* = CSM-K1(CSM) + (K1)(K2)(CSM) – EP – AC

DEFINITIONS:

CSM Computer-summed Medicaid costs: Average Medicaid expenditures (only for the services covered under the insurance plan) from the previous fiscal year, for persons with like demographic data and no third party resources, excluding Medicare. Previous fiscal year costs are adjusted accordingly for inflation and scheduled provider reimbursement rate increases.

Average Medicaid cost is determined for each Medicaid-eligible person in the household by the following demographic data:

1. Age	0 through 60 days	21 years through 48 years
	61 days through 5 years	49 years through 65 years
	6 years through 12 years	66 years through 79 years
	13 years through 20 years	80 + years
2. Sex	Male or female	
3. State Assigned Aid Type	Basis of Medicaid eligibility in mandatory or optional coverage groups.	
4. Institutional Status	Institutionalized or not institutionalized	
5. Medicare Status	Receiving Medicare or not receiving Medicare	

EP Premium amount + deductible.

AC Administrative cost: $50 annually per recipient.

K1 A constant factor to account for the state-specific factor to adjust the Medicaid average covered expense amount for the higher prices employers pay. This facto equals 1.6.

K2 A constant factor which represents the state-specific average employer health insurance payment rate. This factor equals 1.0.

* Savings must equal or exceed $5.00 per month.

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.