

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



Medicaid and CHIP Operations Group

October 19, 2020

Susan Birch, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

Dear Ms. Birch and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the enclosed State Plan Amendment (SPA), Transmittal Number WA-20-0017. This SPA implements CMS guidance regarding Third Party Liability as outlined in the Bipartisan Budget Act (BBA) of 2018. The SPA also updates the threshold dollar amount to open a casualty case file on an injured client, specifically when a paid ambulance claim exists in the Medicaid Management Information System (MMIS), the state's Medicaid payment system known as ProviderOne.

This SPA is approved effective July 1, 2020. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Washington State Plan.

If you have any questions, please contact Betsy Conklin at 206-615-2357 or via email at Elizabeth.Conklin@cms.hhs.gov.

Sincerely,

James G. Scott, Director,
Division of Program Operations

Enclosure

cc:
Ann Myers, HCA
Mark Benya, HCA

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
20-0017

2. STATE
Washington

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2020

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
1902(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2020 \$0
b. FFY 2021 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.22-B page 1 & 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):
Attachment 4.22-B page 1 & 2

10. SUBJECT OF AMENDMENT:

Third Party Liability – Payment of Claims

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Exempt
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:


16. RETURN TO:
Ann Myers
Rules and Publications
Division of Legal Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

13. TYPED NAME:
MaryAnne Lindeblad

14. TITLE:
Director

15. DATE SUBMITTED:
August 27, 2020

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
August 27, 2020

18. DATE APPROVED:
October 19, 2020

PLAN APPROVED – ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
James G. Scott

22. TITLE:
Director, Division of Program Operations

23. REMARKS:
10/13/20: State authorized P&I change to add Attachment 4.22-B page 2 to boxes 8 and 9.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON**Requirement for Third Party Liability – Payment of Claims**

1. The method to determine compliance with requirements of Section 433.139(b)(3)(ii)(B) is as follows: The State Plan as referenced herein requires providers to bill third parties. In a case where medical support is being enforced by the state Title IV-D Agency, the provider will be required to submit written documentation that the third party has been billed and has not received payment from the third party. It must be within 100 days from the date of service before the state will pay.

The Medicaid agency pays for medical services and seeks reimbursement from a liable third party when the claim is for preventive pediatric services as covered under the early and periodic screening, diagnosis and treatment (EPSDT) program contained in Section 433.139(b)(3)(i). If the preventive pediatric service is identified in the MMIS as cost-avoidance based on cost-effectiveness or access to care, section 53102(a)(1) of the Bipartisan Budget Act of 2018 warrants cost-avoidance for 90 days.

State laws are in effect that require third parties to comply with the provisions of 1902(a)(25)(I) of the Social Security Act, including those which require third parties to provide the state with coverage, eligibility, and claims data.

2. Claims for medical services, unless identified under existing state regulations regarding recovery of agency-paid claims from clients' primary insurance carriers, are cost-avoided when a third party liability (TPL) policy exists within the MMIS (the state's Medicaid payment system known as ProviderOne) that matches the benefit coverage-type and service date. Claims paid by the Agency prior to the TPL policy being entered into the MMIS are pursued for recovery through an invoice submitted to the primary insurance carrier. The cost-effectiveness threshold to pursue recovery on a health insurance claim is monitored by the MMIS and invoices claims to the primary carrier if the total claim paid amount is \$15.00 or more.

Generally, casualty insurance claims are pursued for recovery. Paid claims related to an accident/injury on a Medicaid client are manually reviewed. The cumulative paid amount on the claim(s) must exceed \$50.00 to open a casualty case file on the injured client. An ambulance claim with a paid amount equal to or greater than \$220.00 qualifies to open a casualty case file. Additionally, MMIS automatically reviews the paid amount on an accident- or injury-related claim and initiates a Treatment Questionnaire (TQ) letter to the client if the total claim payment is \$110.00 or more.

3. The agency will seek recovery from the third party within 60 days after the end of the month in which payment was made. This does not apply to exceptions for Good Cause or Confidential Services cases. Good Cause and Confidential Services cases include Title IV-D domestic violence cases and certain clients with STD/HIV, pregnancy, or abortion-related services/diagnosis. The agency will also seek recovery within 60 days of the date the agency learns of the existence of a third party or when benefits become available. Claims identified under 4.22-B page 1 (1.) should follow the specified 90 to 100 day waiting period before initiating recovery.
4. When the agency has determined a sum certain receivable amount has been validated and the third party fails to make payment, after 90 days the agency refers the case to the Department of Social and Health Services' Office of Financial Recovery for formal collection activities. These

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

REQUIREMENT FOR THIRD PARTY LIABILITY - PAYMENT OF CLAIMS (cont.)

include skip tracing, payment demands, negotiating debts and repayment agreements, and enforcement action, including legal action. "Sum certain receivable" is when a liable third party (regardless of the third party resource type) and predetermined settlement or recovery has been validated through either court settlement or explanation of benefits (EOBs) and remittance advices (RAs). Claims identified under 4.22-B page 1 (1.) should follow the specified 90 to 100 day waiting period before initiating a referral.

5. For Casualty recoveries, the agency complies with 42 U.S.C.§1396a (a) (25) (B) and uses the following factors and guidelines in determining whether to pursue recovery of benefit, after deduction of the agency's proportionate share of attorney's fee and cost, from a liable party.
 - A. Ascertain the amount of Medicaid lien and the amount of the gross settlement.
 - B. Determine whether the Medicaid lien plus attorney's fees and costs will exhaust or exceed the settlement funds.
 - C. If the answer to 2 is Yes; and if the agency:
 - a. Is informed the client will not pursue the claim; or
 - b. Cannot handle the case, once it is tendered to the agency by the client or the client's attorney to pursue on behalf of the client; or
 - c. Made reasonable effort to ascertain the client's intention regarding the claim, but could not obtain a response;

Then the agency follows the procedures stated in D.
 - D. The agency considers the cost effectiveness principle in determining what is the estimated net recovery amount of be pursued, based on the likelihood of collections. Net recovery amount is defined as that amount of recovered dollars to apply to Medicaid costs. In determining the estimated recovery amount, the following factors are considered:
 - a. Settlement as may be affected by insurance coverage or other factors relating to the liable party;
 - b. Factual and legal issues of liability as may exist between the client and liable party;
 - c. Problems of proof faced in obtaining the award or settlement; and
 - d. The estimated attorney's fee and costs required for the Agency to pursue the claim.
 - E. After considering the above factors, the agency may pursue a lesser recovery amount to the extent that the agency determines it to be cost-effective to do so.