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State/Territory Name: Washington

State Plan Amendment (SPA) #: 16-0018

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104



Division of Medicaid & Children's Health Operations

December 19, 2016

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 16-0018

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the enclosed State Plan Amendment (SPA), Transmittal Number 16-0018. This SPA amends State Plan Attachments 3.1-F Part 2, 4.22 and 4.23 to transition most of the responsibility for third party recoveries to managed care plans and to begin enrollment into Apple Health managed care for those Medicaid clients who have third party coverage.

This SPA is approved effective January 1, 2017.

If there are additional questions please feel free to contact me, or your staff may contact Rick Dawson at Rick.Dawson@cms.hhs.gov or 206-615-2387.

Sincerely,

Digitally signed by David L.

A solid black rectangular box used to redact the signature of David L. Meacham.

Date: 2016.12.20 07:36:53 -08'00'

David L. Meacham
Associate Regional Administrator

Enclosure

cc:
Ann Myers, HCA
Christine Nolan, HCA

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

1. TRANSMITTAL NUMBER:
16-0018

2. STATE
Washington

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

4. PROPOSED EFFECTIVE DATE
Jan. 1, 2017

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a) (25)(I) of the Social Security Act
42 USC 1396a (a) (25) (B)

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 \$749,317
b. FFY 2018 \$991,159

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

4.22-A page 2
4.22-B page 1, 2, 3, 4 (~~new~~) (P&I)
4.23 (~~remove~~) (P&I)
Attachment 3.1-F Part 2 page 6 (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*)

4.22-A page 2
4.22-B page 1, 2, 3
Att. 4.23 (P&I)
Attachment 3.1-F Part 2, page 6 (P&I)

10. SUBJECT OF AMENDMENT

Third Party Liability - Delegation of Third Party Responsibilities to Managed Care Organizations

11. GOVERNOR'S REVIEW (*Check One*):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:

11-9-16

16. RETURN TO:

Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716


FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
11/09/2016

18. DATE APPROVED:
12/19/2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/2017

20. SIG 
22. TITLE: Associate Regional Administrator
Date: 2016.12.20 07:38:10 -08'00'

21. TYPED NAME: David L. Meacham

23. REMARKS:

11/9/16: State authorized P&I change to box 8
12/13/16: State authorized P&I change to box 8 and 9
12/19/16: State authorized P&I change to box 8 and 9

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

REQUIREMENTS FOR THIRD PARTY LIABILITY - IDENTIFYING LIABLE RESOURCES (cont.)

- d. SOURCE
State Department of Transportation
PURPOSE
To match names and dates of birth of Medicaid clients with the Washington State Patrol motor vehicle accident records. A report is produced and staff validate whether third party liability is available.
FREQUENCY
Weekly
- e. SOURCE
Department of Defense
PURPOSE
To match all Medicaid eligible clients to active duty and reserve armed forces members and dependents found in the Defense Eligibility Enrollment Reporting System (DEERS).
FREQUENCY
Annually

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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)(c) 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 he has billed the third party and has not received payment from the third party. It must be at least 30 days from the date of service before the state will pay.

The same method is used to meet the requirements contained in Section 433.139(b)(3)(i).

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. All claims for medical services are cost-avoided if there is a third party liability (TPL) file in the master eligibility file indicating health insurance coverage. Health insurance and casualty claims are generally pursued for collection. However, the cost-effectiveness threshold for pursuit is \$50 for a casualty case.
3. The state Medicaid 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.
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 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).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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.

1. Ascertain the amount of Medicaid lien and the amount of the gross settlement.
2. Determine whether the Medicaid lien plus attorney's fees and costs will exhaust or exceed the settlement funds.
3. 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 4.
4. 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.
5. 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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

REQUIREMENTS FOR THIRD PARTY LIABILITY DELEGATION OF THIRD PARTY RESPONSIBILITIES TO MANAGED CARE ORGANIZATIONS

The Agency does not exempt clients from enrollment in managed care based solely on the presence of third party liability (TPL). The Agency assigns TPL responsibility to managed care organizations by contract.

In order to preserve TPL recoveries in the managed care setting, the state:

- 1) Takes reasonable and prudent steps to spell out TPL responsibilities in managed care contracts and subcontracts.
- 2) Monitors those contracts to assure compliance with TPL responsibilities by managed care plans and their subcontractors.
- 3) Takes appropriate corrective action where there are contract deficiencies and requires reporting by plans on their actual TPL recoveries in order to gauge the accuracy of capitation rate reductions to account for TPL..

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

APPLE HEALTH MANAGED CARE

Citation

Condition or Requirement

2. *Excluded Groups.* Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☐ Other Insurance--Medicaid beneficiaries who have other health insurance

☒ Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

Note: The State intends to enroll clients who are residing in a Nursing Facility into Apple Health Managed Care. The State will not enroll those residing in Intermediate Care Facilities for the Mentally Retarded.

☒ Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☒ Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program

☐ Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver)

☒ Retroactive Eligibility--Medicaid beneficiaries for the period of retroactive eligibility

☐ Other (Please define):

1932(a)(4)

F. Enrollment Process.

1. Definitions

- a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.
- b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

- a. ☒ The applicant is permitted to select a health plan at the time of application.
- i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).