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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 21-0046

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th Street, Suite 355
Kansas City, MO 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid & CHIP Operations Group

March 8, 2022

Kim Bimestefer, Executive Director
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

RE: Colorado State Plan Amendment (SPA) 21-0046

Dear Ms. Bimestefer:

We have reviewed the State Plan Amendment (SPA) submitted under transmittal number 21-0046. This amendment complies with an August 27, 2021 Center Informational Bulletin that assists states in ensuring that their Medicaid state plans comply with Third Party Liability (TPL) requirements reflected in current law.

Please be informed that this SPA was approved on March 8, 2022, with an effective date of December 31, 2021. Enclosed are the CMS-179 and the amended plan pages.

Should you have any questions about this amendment, please contact Curtis Volesky at (303) 844-7033.

Sincerely

[redacted]

Digitally signed by James G. Scott -S
Date: 2022.03.08 17:01:40 -06'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Dr. Tracy Johnson, Tracy.Johnson@state.co.us
Bettina Schneider, bettina.schneider@state.co.us
Russell Ziegler, Russ.Zigler@state.co.us
Jami Gazarro, Jami.Gazerro@state.co.us
Amy Winterfeld, amy.winterfeld@state.co.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21-0046

2. STATE: CO

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 31, 2021

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 433, Subpart D

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.22-B -- Requirements for Third Party Liability -- Payment of Claims -- Pages 2-3 (NEW)

Section 4.22 -- Page 69a

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Section 4.22 -- Page 69a (TN: 94-027)

9. SUBJECT OF AMENDMENT
Comply with a August 27, 2021 Center Informational Bulletin that assist states in ensuring that their Medicaid state plans comply with Third Party Liability (TPL) requirements reflected in current law.

10. 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:
Governor's letter dated 14 July, 2021

Y OFFICIAL
[redacted]

12. TYPED NAME
Tracy Johnson

13. TITLE
Medicaid Director

14. DATE SUBMITTED
December 30, 2021

15. RETURN TO
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: Amy Winterfeld

FOR CMS USE ONLY

16. DATE RECEIVED
December 30, 2021

17. DATE APPROVED
March 8, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
December 31, 2021

19. SIGNATURE OF APPROVING OFFICIAL
[redacted] igitally signed by James G. Scott -S
ate: 2022.03.08 17:02:16 -06'00'

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS
State approved pen and ink change to correct page numbers for Attachment 4.22-B and add Section 4.22 --Page 69a in box 7, and remove Attachment 4.22-B (as not superseded) and add Section 4.22 -- Page 69a in box 8.

Instructions on Back

Requirements for Third Party Liability –
Payment of Claims

1. Cost Avoidance and Post-pay Recoveries.

The State of Colorado's TPL program employs both cost avoidance and pay and recover for payment of claims with third party liability. The emphasis of the program is cost avoidance as this method is the most efficient and effective in ensuring that the costs of claims are borne by the liable third party. For example, claims for prenatal services, including labor, delivery, and postpartum care services will be rejected by the claims system unless providers seek reimbursement from the commercial health payor prior to seeking reimbursement from the Department. Cost avoidance occurs when commercial health eligibility data is identified and loaded into the Department's claims payment system.

There are exceptions to cost avoidance established by federal law and circumstances where cost avoidance is neither cost effective nor efficient. Claims paid when third party coverage data is not available at the time of submission of the claim are pursued for post-payment recovery as described in this attachment.

The State Plan as referenced herein requires providers to bill third parties prior to seeking payment from the Department. When the probable liability of a third party is established, the evidence of benefits triggered by the TPL data contained in the claims payment system notifies the provider that the claim was cost avoided due to the existence of TPL. With this information, the provider can submit the claim to the identified third party for payment by the primary payor and back to the Department for any secondary payment that may be due.

2. Medical Support Enforcement.

The Department will pay and subsequently recover the payment from the commercial health payor if the claim is for a service provided to a Medicaid recipient who is named in a child support enforcement action and where the third party coverage is provided by an absent parent. The provider is required to certify that it has not received payment from the third party payor within 100 days from the date of submitting the claim prior to submitting the claim to the Department for payment. The Department reserves the right to make payment after 30 days from the date of the claim's submission by determining the payment within this timeframe is cost-effective and necessary to ensure access to care for the Medicaid recipient. These claims will be pursued for post-payment recovery by the Department's vendor.

Providers are required to bill the third party and certify to the Department the period of time since the claim's submission to the third party when requesting payment from the Department. *See* 42 C.F.R. §433.139(b)(3)(ii)(A) and (B). The provider's compliance is determined by the documentation submitted to the Department's fiscal agent when the cost avoidance edit is triggered by a claim and does not indicate the amount paid by the third party. *Id.* at §433.139(b)(3)(ii)(C). Such documentation is necessary to overcome the claim's rejection.

3. Preventive Pediatric Services.

The Department pays claims related to preventive pediatric care including EPSDT (early and periodic

screening, diagnostic and treatment) services and recovers such costs from the third party unless the Department has made a determination related to cost effectiveness and access to care that warrants cost avoidance for up to 90 days.

4. Cost Avoidance and Claims Not Covered by Commercial Health Coverage.

The Department also identifies categories of claims that are generally not covered by commercial health coverage. A post-pay recovery methodology in contrast to cost avoidance is more effective under these circumstances. For example, home health claims incurred by an individual on a home and community-based services waiver are not likely to be covered under most commercial health benefit plans. Cost avoidance of such claims causes unnecessary administrative inefficiencies and is neither cost effective nor efficient.

5. Post-payment Processes: Direct Billing and Billing by Providers.

The Department contracts with a TPL vendor to perform post-pay recoveries. The vendor identifies potentially liable third parties by matching Medicaid eligibility data against commercial health plan eligibility data. Paid claims data is matched against the eligibility data to identify claims to be billed to the third party. Additionally, the vendor may provide the commercial health information to the provider in order to bill the claim to the commercial payor. In this instance, the Department recovers the claims payments by retracting the Medicaid payments from the provider in the claims payment system after the provider has received payment from the liable third party.

6. Threshold Amounts for Purposes of Seeking Recovery from a Liable Third Party Pursuant to 42 C.F.R. §433.139(f)(2).

(a) Health Coverage. Recoveries from commercial health coverage on claim types likely to be covered by an insurance policy or a health benefit plan occurs when payments made by the Department are greater than $0.01.

(b) Casualty Recovery. The Department uses a $250 threshold in determining whether to pursue casualty recovery when a liable third party payer has been identified. The Department exercises discretion in pursuing Medicaid liens totaling $250 or less on the basis that pursuing such liens are no longer cost effective.

7. Threshold Amounts and Timing for Purposes of Seeking Recoveries Pursuant to 42 C.F.R. §433.139(f)(3).

(a) Health Coverage. For medical claims that were paid by the Department because any applicable TPL data had not been captured in the claims payment system, recovery is pursued by the TPL vendor for amounts greater than $0.01 if any applicable TPL is identified within three years of the date of service. This timeframe is only one year from date of service if the provider would need to bill the Medicare program.

(b) Casualty Recovery. The Department retains discretion when the claims paid by the Department linked to a personal injury total less than $250 assuming that providers have had a reasonable period of time to submit claims for payment by the Department. Recoveries less than this threshold amount raises the likelihood that a recovery from the liable third party is outweighed by the Department's resources to pursue such a recovery.

Revision: HCFA-PM-94-1 (MB)
September 1994

State/Territory: Colorado

Citation			
42 CFR 433.139(b)(3)(ii)(A)	X	(c)	Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
		(d)	ATTACHMENT 4.22-B specifies the following:
42 CFR 433.139(b)(3)(ii)(C)		(1)	The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).
42 CFR 433.139(f)(2)		(2)	The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
42 CFR 433.139(f)(3)		(3)	The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20		(e)	The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.