(b) ATTACHMENT 4.22-A

(1) The Department of Public Welfare (the Department) conducts daily data exchanges with the Offices of Employment Security (OES) and Unemployment Compensation (UC) in response to inquiries entered on the Income Eligibility Verification System (IEVS). Title IV-A and Social Security Administration (SSA) Wage and Earning Files data exchanges are conducted on a monthly basis. Under contract with the Bureau of Workers' Compensation, data exchanges are accomplished on a biannual basis. Claims with trauma diagnosis codes are identified weekly.

(2) Income Maintenance Case Workers (IMCWs) obtain information regarding possible third party medical resources carried through employment by entering the social security numbers of every applicant, recipient, legally responsible relative, and absent and custodial parent on IEVS. This procedure is followed for each initial application and each redetermination process. All data exchange information maintained on IEVS is available within 30 days of inquiry. IMCWs review summary reports daily to determine if responses requiring disposition were received. Employment information is explored for possible third party resources. Any third party resources are incorporated into the eligibility case file and the third party data base.

Data exchanges are conducted with the Department of Labor and Industry Bureau of Workers' Compensation biannually. The information obtained from the Workers' Compensation data exchange is added to the third party data base and the eligibility case file within two weeks of receipt of a tape.

Resources added to the third party data base are used to cost avoid payments when a third party coverage is available. Claims paid prior to the Department's knowledge of third party coverage are recovered.

(3) The Department has determined that a data match with the State Motor Vehicle Accident Report files cannot be pursued at this time. Common matching criteria for such an exchange could not be established.

(4) All claims with trauma diagnosis codes BOO-999 International Classification of Disease, 9th Revision, Clinical Modification, Volume 1, (ICD-9-CM), with the exception of 910.10, 910.20, 910.30, 910.40, 910.S0, 910.60, 910.70, 911.00, 911.10, 911.20, 911.30, 911.40, 911.S0, 911.60, 911.70, 912.10, 912.20, 912.30, 912.40, 912.S0, 912.60, 912.70, 913.10, 913.20,913.30, 913.40, 913.S0, 913.60, 914.10, 914.20, 914.30, 914.40, 914.S0, 914.60, 914.70, 914.80, 914.90, 91S.00 - 916.9, 916.20, 916.30, 916.40, 916.70, 916.80, 916.90, 917.00 - 917.90, 919.00 - 919.90, 991.00 - 991.90, 992.00 - 992.90, 993.00 - 993.90, and 994.6, are identified in each weekly claims processing cycle. In addition the Department uses ICD-9-CM codes V54.00, VS4.80, VS4.90, V57.00, V57.10, V57.20, V57.30, V57.40, V57.80, V57.81, V57.89, and V5790 to identify claims for possible recovery. A questionnaire is sent to the recipient with aggregated paid claims equal to or in excess of $250. If there is no response within thirty (30) days, a second questionnaire is sent to any recipient with aggregated paid claims of $1,000 or more. If no response is received from the second request within thirty (30) days and the aggregated paid claims total $5,000, a copy of the questionnaire is sent to the recipient's caseworker. The caseworker contacts the client to secure details on any liable third party. When questionnaires are returned, staff review the responses to determine third party resource availability. Where a resource exists, the information is entered in the third party liability case file within 60 days and recovery is pursued.

Those diagnoses that are excluded from the trauma code editing were determined through a review of five months worth of data where claims never reached the $250 threshold.

Periodic reviews of the cases pursued for recovery as a result of the trauma diagnosis code edits are conducted and those diagnosis codes that produce the greatest yield are identified. Future cases identified with these diagnosis codes are given priority status for recovery.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Pennsylvania

STATE REGULATION TO TRACK CLAIMS PAID WHEN A RECIPIENT IS INVOLVED IN AN ACCIDENT OR A TRAUMA REALATED INJURY

1902(a)(25) Effective January 1'1, 2009 PROMISe ™ will begin recognizing Supplementary Classification of External Causes of Injury and Poisoning (E Codes) when processing trauma claims and will begin to generate Trauma Code Tracking (TCT) questionnaires and increase accident recoveries. These E Codes are in addition to the trauma diagnosis codes 800 through 999 currently in use.

The State currently has a process in effect that monitors claims paid for certain diagnosis. This is to determine if the state may be able to seek payment from another party because of pending litigation or a primary insurance carrier liability. Title XIX§1902(a)(25) mandates the recovery of any funds paid by Medical Assistance (MA) when another resource is legally liable for those costs.

The State's mechanized claims processing system (PROMISe TM) uses edits mandated by the federal government, hence, the TCT System. The system currently includes most of the 800 and 900 International Classification of Diseases 9th Revision (ICD9) codes as well as some from the 300 and some V codes. The purpose of the edits is to review the claims and check for casualty accidents and other liable parties, TCT questionnaires are then generated by PROMISe® and sent to recipients.

In May 2007 the UB92 claim form was discontinued and replaced with the UB04. This revision included changes for institutional health care providers. The UB04 now recognizes the Supplementary Classifications of External Causes of Injury and Poisoning, otherwise known as E Codes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Pennsylvania

E Codes additions for TCT process:

E800 through and including E819
E822 through and including E844
E846 through and including E899
E905 and E906
E910 through and including E949
E960 through and including E977
E979
E980 through and including E989

THIRD-PARTY LIABILITY

The Third-Party Liability (TPL) Program is designed to function primarily as a cost avoidance system.

Pennsylvania complies with the following requirements:

- Social Security Act Section 1902(a)(25)(E): Applying cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services.
- Social Security Act Section 1902 (a)(25)(E): Making payment without regard to potential third-party liability for pediatric preventive services, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.
- Social Security Act Section 1902 (a)(25)(F): Making payment for claims related to child support enforcement beneficiaries without regard to potential third-party liability, if payment has not been made by the third party within 100 days after the provider submitted a claim to the third party, except that Pennsylvania may make such payment within 30 days after such date if it determines doing so is cost-effective and necessary to ensure access to care.

Threshold amount or other guidelines used to seek recovery (42 CFR 433.139(f)(2)):

The Department will seek recovery unless the agency determines that the recovery will not be cost effective. The agency uses the threshold amount of $50 as a guideline in its attempts to recover from liable third parties for health insurance. This $50 guideline is used in consideration with other factors, such as expense and difficulty of recovery, in deciding whether to pursue recoveries in the range of smaller dollar expenditures (less than $50). The threshold amount of $250 is used to determine the recovery of funds for casualty claims. The threshold amount may be waived when the agency deems it to be economically and administratively feasible to collect less than the stated amounts. The threshold amount is based on effectiveness with normal effort for the recovery of funds. Should it be determined that a recovery effort would be cost effective, then attempts are made for recovery of amounts below the threshold levels.

Reimbursement recovery threshold (42 CFR 433.139 (f)(3)):

The Department accumulates claims for six months in an attempt to reach the threshold. The threshold for casualty claims is $250 and $50 for health insurance claims.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

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

1. Determine Medicaid costs through the Pennsylvania Medical Assistance Management Information System (MAMIS) for services covered by the group health insurance plan. Cost data will be categorized according to (but not limited to) age, sex, geographic location, and eligibility category (or grouping of categories) of assistance.

2. Determine group health insurance plan costs. The policy information needed to determine the cost of the group health insurance plan is:

    - Effective date of the policy
    - Exclusions to enrollment
    - Services covered under the policy
    - Limitations on services and/or costs
    - Premium, deductible and co-insurance amounts

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

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

3. Determine the State administrative cost by dividing the total administrative costs of the HIPP program by the total projected number pf yearly referrals to the program for cost effective determination. The administrative cost in the formula may be adjusted through operational phases of the program.

4. Calculate cost effectiveness. Compare costs under Medicaid (step 1) to costs under the group health plan (step 2) plus administrative costs (step J). It is cost effective if the costs to the State under the group health plan plus administration are likely to be lower than the cost to the State for these services under Medicaid.

5. A recipient's specific health related circumstances may be considered. The system calculates a percentage add-on to Pennsylvania's Medicaid cost (identified in step 1) for the diagnosis identified. It is

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

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

cost effective if the costs to the State under the group health plan plus administrative costs are likely to be lower than the cost to the State for the specific medical condition under Medicaid.

6. When it is determined to be cost effective, HIPP shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However, the needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness and payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

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