Medi-Cal Program Guide (MPG) Letter #681

June 23, 2009

Subject **HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (HIPP), REMOVAL OF OHC CODES FROM MEDS FOR ADULT AND CHILDREN VICTIMS OF DOMESTIC VIOLENCE AND THE ELIMINATION OF THE HEALTH INSURANCE QUESTIONNAIRE FORM (HIQ)**

Effective Upon receipt

Reference ACWDL 08-59, 09-02 and 09-25

Purpose The purpose of this letter is to inform staff of:

- Changes to the HIPP program eligibility criteria.
- The elimination of the HIQ DHS 6155 as a means to communicate Other Health Care (OHC), changes to OHC or termination of OHC.
- Procedures for removal of OHC for victims of domestic violence.

Background HIPP

Prior to January 2008, in order for a beneficiary to be eligible for the HIPP program, their share of cost (SOC) had to be $200 or less.

HIQ

Previously, workers used the HIQ form as a means to communicate OHC for new applicants, or changes and terminations to OHC for existing beneficiaries. DHCS now has more efficient ways of obtaining up to date OHC information such as tape matches with health insurance carriers, automated batch transactions from county systems such as the CalWIN OHC screens and other automated systems.

Domestic Violence

Both adults and children can be victims of domestic violence and abuse. When the decision is made by the abused adult or child to

leave the home, they need protection from the abuser who often is enraged and attempting to find the abused individuals. It is critical that the abuser be prevented from obtaining the new address of the victims in order to ensure their safety.

In most cases, the victims are in immediate need of medical care. If they obtain Medi-Cal services, the abuser's OHC will appear in MEDS and OHC will be billed for covered services. When this happens, an explanation of benefits (EOB) statement is sent to the OHC holder, which in these cases is the abuser. The EOB will indicate where the victims obtained services and, consequently, place the victims at risk for additional abuse.

It is critical that OHC codes be permanently removed from MEDS to ensure the safety of victims of domestic violence when they access Medi-Cal services. When the worker learns that a Medi-Cal beneficiary is the victim of domestic violence, the worker must have the OHC coding removed right away.

Summary of Changes

HIPP program

- Eliminate maximum SOC limit (formerly $200 per month) in order to qualify for HIPP.
- Use DHCS 6172 (HIPP Premium Payment Application) instead of the DHS 6155 to refer applicants and beneficiaries to HIPP.

DHS 6155 Form

- Workers will no longer send DHS 6155 to alert DHCS of OHC, changes to OHC or termination of OHC.
- Workers must report changes and terminations of OHC via the secure fax lines:

    1. 916-650-6582
    2. 916-650-6585
    3. 916-650-6580

  Faxes must include the beneficiary's

    1. Client Index Number (CIN)
    2. Name
    3. Last 4 digits of their MEDS ID
    4. Health Plan information.

In addition to the fax lines, the Wide Area Telephone Service number (1-800-952-5294) is available for assistance with other health coverage issues.

- Workers will provide proof of OHC termination **only** at the request of DHCS.

Domestic Violence

To remove the OHC code, workers will contact DHCS by sending a fax to 916-464-0851

The fax must include the following information:

- Name, CIN and date of birth of each Medi-Cal beneficiary who is a victim of DV
- Name of the OHC carrier
- Date needed to terminate the OHC code
- Statement indicating that the OHC is blocking access to care for the abused victims
- Indicate on the cover sheet that the fax is related to domestic violence.

NOTE: Workers must remove the OHC code the day they learn a beneficiary is the victim of domestic violence.

If a response is not received from DHCS within 24 hours of the request, the worker must call 1-800-952-5294 to follow up on the request.

Automation Impact

None.

Forms Impact

DHS 6155 Health Insurance Questionnaire

This form may still be used by workers to collect other health care information from applicants and beneficiaries, but may not be used to communicate health information with DHCS.

DHCS 6172 Health Insurance Premium Payment Application

This form is used to refer applicants and beneficiaries to HIPP. It is uploaded to iWAY and available for order from DHCS.

Quality Assurance Impact

Effective with the August 2009 review month, Quality Assurance will cite with the appropriate error any case that does not follow the requirements of this letter.

Summary of Change

The table below shows the changes made in the MPG.

Section	Summary of Change
Article 15, Section 1	• Infomapped the section • Added new OHC removal procedure • Removed the SOC limit from HIPP eligibility criteria. • Added DHCS 6172 information. • Changed OHC reporting methods.
Article 15, Section 1 Appendix G	Added a copy of DHCS 6172

Manager Approval

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MK

Article 15 Section 1 – Other Health Coverage (OHC)

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15.01.01 Introduction

A. General

Medi-Cal applicants/beneficiaries are required to report and use any OHC to which they are entitled. The Medi-Cal program is designed by law as the payor of last resort for health care services/benefits. Health insurance carriers are obligated to reimburse the Medi-Cal program for the cost of any health care services received by a beneficiary when they are covered under the terms of an insurance policy. MEM PROC. 15A

Money collected by Medi-Cal from insurance carriers is used to pay for health care benefits.

MPG Letter #325 (11/95)

B. Description

Other health coverage is any benefit for health related services or entitlements for which a Medi-Cal beneficiary is eligible under any private, group, or government insurance program.

The following table lists examples of policies that provide OHC:

Type	Benefit Provided
Dental	Policies that provide dental services only.
Cancer	Policies that cover medical expenses related to cancer treatment only.
ERISA Trusts	Any health insurance that is offered through a trust fund operating under the authority of the U.S. Department of Labor.
Health	Policies that cover hospital expenses, surgical expenses, routine medical expenses, or major medical. Life, Automobile, and Burial Insurance are not considered Health Insurance.
Hospital	Policies that cover expenses incurred during hospitalization.
Indemnity	Policies that pay benefits in the form of cash payments. These benefits are paid directly to the insured not to the provider of services.
Medicare Supplement	Policies that pay the portion of Medicare covered services which Medicare does not pay.
Major Medical	Policies that cover medical expenses over and above those expenses covered by a basic medical benefit plan.
Prescription	Policies that cover prescribed drugs only.
Student Health	Health insurance offered through an educational

	institution for enrolled students. These cover off-campus medical expenses and are underwritten by a private insurance carrier.
Surgical	Policies that cover surgery-related expenses only.
Vision	Policies that cover vision-related expenses only.
LTC Health Insurance	State certified LTC policies that cover long term care services (see Article 9, Section 13).
Medicare HMO	Individuals who have coverage through Medicare HMO must be coded F in MEDS. To code a person F in the automated system, select Medicare Risk HMO from the health coverage drop down box on the health care information section of the collect individual attributes window. If the Medicare HMO is identified by CDHS, there is OHC "F" still needs to be entered.

ACWDL 94-82

ACWDL 96-26

MPG Letter #325 (11/95)

C. Applicant/ Beneficiary Responsibility

Report Any OHC Entitlement

MEM 50763
ACWDL 96-58

Applicants/beneficiaries for Medi-Cal are required to report OHC as a condition of eligibility. This requirement applies at application, reapplication or redetermination (if not previously reported), and within 10 calendar days from the date of changes in their OHC.

Eligibility cannot be approved or continued if the applicant/beneficiary, who indicates OHC on the Statement of Facts, fails to provide the required health insurance information by completing the Health Insurance Questionnaire (DHS 6155) or providing the information during the interview.

MEM 50167

Verify OHC

Acceptable verifications of OHC include, but are not limited to:

- Insurance policies which specifically name the applicant;
- Health benefit identification cards or letters from health care benefit providers;
- Letters from the Workmen's Compensation Board, employers or insurance companies, for health care benefits available through work related injuries or settlements from prior injuries.

Use OHC Before Using Medi-Cal

Medi-Cal beneficiaries must use any available OHC to pay for health services prior to using Medi-Cal.

MEM 50771

Reimburse DHCS For Any Payments

Beneficiaries are required to reimburse DHCS for any payments received for health care services paid for by Medi-Cal when the payment received was from a federal or state program or from a legal or contractual entitlement.

See Article 15, Section 3 for instructions on reimbursement of payment(s) received.

MPG Letter #383 (4/97)

D. County Responsibility

The worker is responsible for identifying any OHC available to applicants/beneficiaries, providing general OHC information to applicants/beneficiaries and transmitting OHC information to DHCS. OHC information is transmitted to DHCS by coding entered in the automated system and submitted to MEDS. MEM 50765

Identify OHC

The worker must review the applicant/beneficiary's response to the private health insurance question on the Statement of Facts. MEM 15A.5

If YES, see OHC Coding and Health Insurance Questionnaire Requirements.

If NO:
- Is the applicant/beneficiary employed, or
- Was the applicant/beneficiary recently employed, or
- Does the applicant beneficiary have OHC available through an employer or employed family member, and has not enrolled, or is retired, serves or has served in the Armed Forces, or
- Is there an absent parent?

Appendix G provides a series of key questions to be used to explore potential OHC available to the applicant/beneficiary. If there is no positive response and non-availability of insurance is determined, there is no need to complete the DHS 6155.

Informing Applicant/Beneficiaries
Worker will provide the following information to applicants/beneficiaries:

- Reporting OHC Does Not Affect Medi-Cal Eligibility
  a. Inform applicant/beneficiaries that having and reporting

OHC does not in any way interfere with their eligibility for, or use of, Medi-Cal benefits.

b. Under federal law Medi-Cal providers cannot deny care because a beneficiary has OHC.

- Do Not Advise Applicants/Beneficiaries To Drop OHC
  a. The only exception is if they are on Medicare. Federal law requires us to inform the applicant/beneficiary they do not need Medigap insurance.

- Responsibilities to Report and Apply For/Retain Employer Related Health Coverage Benefits
  a. Advise applicants/beneficiaries that federal law requires an individual, as a condition of Medi-Cal eligibility, to report employer related health insurance benefits available to him/her. The Medi-Cal program may pay the premium if it is determined to be cost effective.
  b. Workers will forward any information obtained from applicant/beneficiaries with available employer related health insurance to DHCS, Health Insurance Premium Payment Program for review of cost-effectiveness (HIPP).

MPG Letter #350 (3/96)

E. Repayment of Insurance Reimbursement

Applicant/beneficiaries must report and repay Medi-Cal for services received under Medi-Cal but reimbursed by their insurance provider.

The worker will instruct the applicant/beneficiary to forward reimbursement payments to:

California Department of Health Care Services
Third Party Liability Branch – MS 4719
P.O. Box 997424
Sacramento, CA 95899-7422

Beneficiaries should endorse checks from insurance carriers as follows:

- "For Deposit Only to Health Care Deposit Fund" -- This will ensure that the check will be properly applied to the State fund only.
- Name of Payee -- Party to whom the check is made payable.
- Medi-Cal Identification Number of Beneficiary -- This may be a person different than the one who received the check.
- Payment must be signed by either the payee or his/her agent.

The applicant/beneficiary must enclose with the check the following

information:

- Date(s) of service,
- Provider's name, and
- Daytime phone number where they can be reached.

MPG Letter #560 (08/04)

15.01.02 OHC Coding and MEDS

A. OHC Coding

The state has two methods for utilizing OHC information on Medi-Cal beneficiaries - Cost Avoidance and Post Recovery. Under cost avoidance, the service provider must bill the OHC provider **prior** to billing Medi-Cal. Claims for beneficiaries with cost avoidance coverage will not be paid by Medi-Cal without an Explanation of Benefits (EOB) from the OHC provider.

The EOB lists payments made for any part of the medical services which were covered by the beneficiary's policy. Cost avoidance OHC codes on Medi-Cal cards alert the providers to the fact that the beneficiary has other health insurance that must be billed before Medi-Cal. Scope of coverage codes tell providers what services are covered. ACWDL 91-38

Under the post recovery, Medi-Cal bills the OHC provider **after** paying the service provider. This is also known as the pay and chase method.

<u>DHCS Placement of Cost Avoidance OHC Codes on MEDS</u>

DHCS places cost avoidance OHC codes on MEDS as a result of information received from computer matches with health insurance companies. ACWDL 97-16

<u>Effective Dates of OHC Codes</u>

When the worker determines that the use of a OHC code is appropriate, the effective date of the OHC code is determined as follows:

- New Applicants - the first month of eligibility
- Redeterminations – the future month ACWDL 95-54

<u>Residence Outside OHC Service Area</u>

When the applicant/beneficiary reports that he/she lives outside the service area of the health plan with which he/she has coverage, or must travel more than 60 miles or 60 minutes to receive care from the plan, OHC "A" must be entered. This will allow the state to recover claims paid for emergency services by Medi-Cal for individuals residing out of their plan's service area.

- "Outside Health Plan Area" will be noted in question number 1, next to the insurance carrier's name. ACWDL 91-38
- The applicant/beneficiary will be coded “A” for post recovery via the county automated system. To enter code A, select “Non-Cost Avoid – Any other” from the from the health coverage drop down box on the health care information section of the collect individual

attributes window.

DHCS Placement of Scope of Coverage Codes

DHCS places "Scope of Coverage" codes on MEDS from the information provided on the automated transaction from the county automated system. These codes will appear on the Medi-Cal record. The service provider will then know whether to bill the OHC provider or Medi-Cal.

MPG Letter #350 (03/96)

B. OHC Automated Matches

Although MEDS records are updated by DHCS as a result of tape matches with insurance companies, this does not automatically update the CalWIN. DHCS will periodically send tape match listings to the county so that county records can be updated. The listings are referred to as "Other Health Coverage Indicator Change Reports."

- Upon receipt of the OHC Indicator Change Report, the worker must change the OHC code in CalWIN. The reports will include the cost avoidance OHC code for the policyholder only. Dependent data is not included in the tape matches. County Policy

- At the next redetermination following receipt of an OHC Indicator Change Report which indicated coverage, the worker must determine if dependents of parent(s) identified in the tape matches are also covered by the same insurance policy. The appropriate OHC code must be entered on the automated system for each covered dependent. County Policy

- If the beneficiary claims that the dependent(s) is not covered by the insurance policy, the worker must document this in case comments.

MPG Letter #387 (05/97)

C. Termination of OHC and Removal of OHC Codes

Methods Of Notifying DHCS: ACWDL 09-25

Workers must notify DHCS when a beneficiary's OHC has been modified, changed or terminated. Workers will contact DHCS using the appropriate method: ACWDL 03-39

Method	Reason	Time for Transaction
Call Toll Free: 1-800-952-5294	• Modify • Termination	2 Business Days

	• Immediate Need	
Fax Request to 1-916-650-6585 or 1-916-650-6582	• Modify • Termination • Immediate Need	4 Business Days
Automatic Batch Transaction	• Report New OHC • Modify • Termination	2-60 Calendar Days

All termination requests, including immediate need, must include:

ACWDL 03-39

- Client Name
- Client CIN or County ID # (preferably CIN)
- Termination Date
- Carrier Name (s)
- Reference the Verification you received

DHCS Clarification

Required Actions for Requesting Termination of Coverage

When notified that an applicant/beneficiary's OHC has terminated, the worker will take the appropriate actions for the method used:

Step	Action	Method
1	Request verification	• All
2	Update existing or complete new OHC information in the automated system.	• Fax • Mail
4	Transmit information to DHCS utilizing desired method (phone call, fax, or batch entry).	• All
5	Change OHC code(s) to "N"	• All
6	Reevaluate budget if premium no longer paid	• All
7	Retain copies of all documentation	• All
8	Document method used and all actions taken in case comments (Appendix F)	• All

Immediate Need Termination of OHC Code

When the presence of an incorrect OHC code is a barrier to immediate medical care or when good cause exists, the worker will use either the Toll Free Number or Fax to request removal of the erroneous OHC. If sending a fax, the worker must indicate **"URGENT"** on the fax coversheet for expedited processing.

EW 15 and EW 55 are not to be used to remove OHC codes from MEDS for an immediate need. EW15 and EW55 transactions are used for card generation only. To remove the OHC code for an immediate need request, staff must contact Third Party Liability's Health Insurance Section by phone or by fax.

ACWDL 03-39

COBRA

If a beneficiary provides evidence that continuation of medical benefits is available under COBRA, and the beneficiary has a high cost medical condition, the worker must complete a new DHCS 6172 and send it to:

Department of Health Care Services
Health Insurance Premium Payment Unit
MS 4719
P.O. Box 997422
Sacramento, CA 95899-7422

Healthy Families Indicator Code "9"

ACWDL 00-25

HF OHC code "9" cannot be changed in MEDS through any County transaction. Inquiries regarding the HF OHC code must be directed to HF at (800) 880-5305.

ACWDL 03-39

ACWDL 00-25

SSI/SSP Client Reporting Termination of OHC

When an SSI/SSP recipient informs the MEDS clerk that his/her OHC has terminated, the MEDS clerk with refer the SSI/SSP person to the SSI/SSP Liaison. The liaison will contact Third Party Liability via 1-800-952-5294.

DHCS will remove the OHC via a MEDS transaction.

NOTE: OHC terminations for all Medi-Cal recipients including SSI/SSP eligibles need only be verified upon request from DHCS.

MPG Letter #681 (06/09)

D. Removal of OHC Codes Due to Domestic Violence

ACWDL 08-59

OHC codes must be removed from MEDS for children and adults who have left their homes due to domestic violence (DV) caused by another adult in the household that has OHC. To remove the OHC code, workers will contact DHCS by sending a fax to 916-464-0851.

The fax must include the following information:

- Name, CIN and date of birth of each Medi-Cal beneficiary who is a victim of DV (all persons who have left the home of the abuser)
- Name of the OHC carrier
- Date needed to terminate the OHC code
- Statement indicating that the OHC is blocking access to care for the abused victims
- Indication on the cover sheet that the fax is related to domestic violence.

NOTE: Workers must remove the OHC code the day they learn a

beneficiary is the victim of domestic violence.

If a response is not received from DHCS within 24 hours of the request, the worker must call 1-800-952-5294 to follow up on the request.

MPG LTR NO. 681 (06/09)

E. Change in OHC

When a beneficiary reports that existing OHC has terminated and he/she now has other medical coverage the worker must first terminate the existing coding using one of the methods above.

The worker must then report the new OHC on the following business day. Termination of one OHC and reporting of a new OHC cannot be completed on the same day.

<u>Information needed for Addition of OHC:</u>

State Clarification

- Client name
- Client CIN
- Carrier Name(s)
- Policy Number
- Policy holder name
- Start Date
- Scope of Coverage

MPG Letter #681 (6/09)

F. Modification of OHC

When a beneficiary reports a modification to existing OHC, workers must use the Toll Free Number or Fax to report the modifications. Modifications may include changes such as:

- Beneficiary name or address
- Carrier contact information
- Scope of coverage
- Policy information
- Dependents

<u>Modification requests must include the following information:</u>

State Clarification

- Client Name
- Client CIN or County ID # (preferably CIN)
- Termination Date
- Carrier Name (s)
- Reference the Verification you received

- Specify what needs to be modified

MPG Letter #681 (06/09)

G. Multiple OHC Codes

If an applicant/beneficiary reports multiple policies, one of them is an HP/HMO/CMP, use the appropriate PHP/HMO/CMP code (K, C, P or F). Otherwise, assign the appropriate cost avoidance code for the carrier that provides the most comprehensive coverage.

MPG Letter #441 (02/01)

H. OHC Code Exclusions

The following types of OHC are excluded from the coding requirements and reporting to DHCS: MEM Proc 15A

- Medicare; except a Medicare HMO which must be coded "F". To enter code F, select "Medicare HMO" on the from the health coverage drop down box on the health care information section of the collect individual attributes window ACWDL 96-26
- Most VA benefits, except TRICARE.
- Accident, automobile, burial and life insurance benefits.
- Coverage under Managed Care. See Appendix A.
- Disability and Workers' Compensation benefits.
- Coverage Considered Unavailable.

In the following situations, coverage will be considered unavailable: MEM PROC 15A4

- The parent or guardian refuses to provide the necessary information due to "good cause." Good cause exists when cooperation in securing medical support and payments, establishing paternity, and obtaining or providing information concerning liable or potentially liable third parties from the absent parent can be reasonably anticipated to result in serious physical or emotional harm to the child for whom support is to be sought or to the parent or caretaker with whom the child is living; or
- The absent parent cannot be located; and
- Any coverage to which a child may be entitled when the child is applying for minor consent services. The obligation to utilize OHC before Medi-Cal is modified in those situations where utilization of OHC would violate a person's right to confidentiality regarding his/her Medi-Cal status; such as minor consent.

MPG Letter #350 (03/96)

15.01.03 Health Insurance Questionnaire

A. Requirements

Applicants/beneficiaries who indicate that they have any medical coverage not listed in A. OHC Coding must supply all OHC information during the face to face interview or complete a Health Insurance Questionnaire (DHS 6155). This form was previously used to send OHC information to DHCS. ACWDL 89-31 89-60 89-89

As of June 2009, this form is no longer used to communicate OHC with DHCS. The form can still be used by county staff to gather OHC information from applicants and beneficiaries during the mail-in process or during a face to face interview where the applicant does not have all of the OHC information available. Applicants and Beneficiaries are only required to provide the missing information, no signature is required. ACWDL 09-25

Beneficiaries who have cost avoidance codes added retroactively must complete a form DHS 6155 to show the onset date of OHC.

MPG Letter #681 (06/09)

B. Obtaining OHC information

Workers must attempt to obtain OHC at face to face interviews and enter the information into the automated system.

The DHS 6155 can be used to collect OHC in the following situations:

#	Situation
1	When workers cannot get the OHC information from the client in a face to face interview or by phone.
2	When a returned IEVS abstract reflects employment not previously known. If the form is returned indicating OHC exists, enter the OHC information in the automated system. If the unreported employment is discovered by OSU, OSU will let the worker know that a DHS 6155 must be sent to the client.
3	Send form DHS 6155 to a beneficiary for completion when he/she reports a change in OHC. The beneficiary is to be allowed 20 days to complete and return the form or supply the information in person or by phone.

ACWDL 95-56

Workers will advise the applicant/beneficiary to complete and sign the DHS 6155 when possible. However, if it is not practical for him/her to complete and sign the DHS 6155, the worker may obtain other health coverage information over the telephone and complete the DHS 6155

without the client's signature.

MPG Letter #681 (06/09)

C. Processing the DHS 6155

Workers will take the following actions when DHS 6155 is received: ACWDL 96-24

Step	Action
1	Check the returned form for completeness. • Ensure the policy holder's SSN is provided. • Applicant/beneficiary signature is not required.
2	Allow the applicant/beneficiary 10 days to return a completed form or supply the information by phone or in person if all necessary information is not complete or is unavailable.
3	If not returned within 10 days or the information is not relayed by phone or in person, send a NOA allowing an additional 10 days to respond prior to taking negative action.
4	For DDSD pending, retain the completed form until such time as Medi-Cal is granted.
5	If the applicant checks three of the first four coverage categories (hospital stays, hospital outpatient, doctor visits and prescription drugs) in question #10, code the case on MEDS for cost avoidance.
6	If the applicant indicates PHP/HMO coverage or answers 'yes' to question #2, code the case on MEDS for PHP coverage.
7	Retain a copy of the completed form DHS 6155 for the case record.
8	Forward form DHS 6155 to the CMS Administrative Contractor at M.S. P556, for CMS only cases or cases in which the only persons covered by the OHC are CMS eligibles. ACWDL 09-25
9	Notify the Medi-Cal Health Insurance Unit whenever a granted case has changes in person number, or when the aid code changes by 10's (i.e., 10 to 20, 30 to 80, etc.) for a beneficiary covered by medical insurance. See 15.01.02.C for methods of reporting changes.
10	Deny/discontinue the case if the applicant/beneficiary does not return the completed form DHS 6155 or fails to report the OHC information by phone or in person timely . Form DHS 6155 may be rejected because of the following reasons: • The applicant or person completing the Statement of

	Facts failed to provide necessary verification; or • Lack of cooperation with the county department in resolving incomplete, inconsistent, or unclear information on the Statement of Facts.

MPG Letter #681 (06/09)

D. Managed Care

ACWDL 96-24

Counties with Medi-Cal Managed Care

Counties must continue to report OHC to DHCS even if there is a Medi-Cal Managed Care plan (APPENDIX A) This allows DHCS to:

- Cost-avoid and retrobill the private insurance company for health services rendered to the beneficiary before Managed Care enrollment.
- Immediately begin cost-avoiding Medi-Cal services should a beneficiary disenroll from a Managed Care plan because of intra-county transfer, change of aid type, or exceeding the plan's allowed maximum benefits.
- Provide OHC information to the Managed Care plans and their providers through MEDS and the automated eligibility verification process, thus allowing the plans to coordinate benefits with the OHC.
- Provide OHC data to out-of-county providers.

MPG Letter #392 (07/97)

15.01.04 Medicare HMO Premium Payments, Health Insurance Premium Payment (HIPP), and Employer Group Health Plan (EGHP)

A. Medicare HMO Increased Premium Amounts

State Payment of the Medicare HMOs Increase Premium Amounts for Selected Full-Scope Medi-Cal Beneficiaries ACWDL 01-28

Effective January 1, 2001 DHCS began paying Medicare HMO premium increases not covered by Medicare for certain Medi-Cal beneficiaries enrolled in selected Medicare HMO Plans. TPL determined that it would be more cost effective to have Medi-Cal pay the increased HMO premiums for eligible beneficiaries receiving both Medi-Cal and Medicare rather than have them disenroll and obtain their medical care on a fee-for-service basis.

- A Medicare beneficiary is eligible to have their increased Medicare HMO premium paid by the State if he/she is:
  a. A full-scope Medi-Cal beneficiary, including both SOC and no SOC beneficiaries,
  b. Enrolled in one of the Medicare HMO plans affected by this change, and
  c. Enrolled in a plan that includes both brand name and generic drugs.

Note: Beneficiaries of QMB, SLMB or QI Programs who are not receiving Medi-Cal, are not eligible to have the increased Medicare HMO premium paid by the State.

Affected Health Plans

Beneficiaries who meet the eligibility criteria and belong to the following Medicare HMOs will have the increased premium paid by the State:

- Blue Shield
- Blue Cross
- Health Net
- Pacificare
- Kaiser

Listing of Eligible Medicare Beneficiaries ACWDL 01-28

DHCS compiles a monthly listing identifying Medicare beneficiaries who will have their increased Medicare premium paid by the State. The listing, entitled “Medicare HMO Members - Premiums Paid by Medi-Cal,” is produced for each county in alphabetical order by the beneficiary’s last name. This report will be distributed to FRCs with granted Medi-Cal staff to confirm the premium payment when responding to beneficiary inquiries. Medicare beneficiaries with

questions regarding their payment status may call the TPL toll free number, (866) 227-9863.

Required Worker Actions

Medicare HMO premiums will be treated as follows according to MPG 10-6-3L:

- The increased Medicare HMO premium will be treated as a health insurance deduction if the Medicare beneficiary provides proof that he/she is paying the premium and the individual is not identified on the listing.
- The increased Medicare HMO premium will be removed as a health insurance deduction if information is received that the State is paying the premium.

All case action taken because of the increased Medicare HMO premium must be documented in case comments.

MPG Letter #449 (05/01)

B. Health Insurance Premium Payment Program

DHCS is authorized to pay health coverage premiums on behalf of medical beneficiaries through the Health Insurance Premium Payment Program (HIPP) whenever it is cost effective. Paying these premiums for high cost medical users results in reduced Medi-Cal costs. ACWDL 90-23 & 95-72

Counties are responsible for identifying the existence or availability of private or group health insurance and assisting Medi-Cal beneficiaries in completing a DHCS 6172 (Appendix H). Information from the DHCS 6172 is used to help DHCS evaluate for HIPP. DHCS will notify the county on form DHS 6036A if it will be paying the health care premiums. When the county is notified that the beneficiary has been accepted to the HIPP program, the worker will review the SOC and recompute the budget it if necessary. ACWDL 09-25

HIPP Qualifying Factors

A person is potentially qualified for HIPP if:

- There is current Medi-Cal eligibility. ACWDL 91-08 & 09-02
- There is a high cost medical condition for which the average Medi-Cal covered monthly cost is twice the amount of the monthly health insurance premium, or the medical condition is one of those listed in Appendix E. ACWDL I-97-15
- There is a current private or group health insurance coverage, or COBRA continuation, or a conversion policy, in effect or available.
- Application is made in a timely manner.
- The policy does not exclude the high cost medical condition.
- The premiums are not the responsibility of an absent parent.
- There is no enrollment in a Medi-Cal related pre-paid health plan. ACWDL 95-71

- The client's health insurance policy must not be issued through the California Major Risk Medical Insurance Board.

Required Worker Actions
The worker will:

ACWDL 09-25

Step	Action
1	Issue a DHCS 6172 to the beneficiary to complete during the application and redetermination process when the beneficiary indicates: • That private or group health insurance is available, but has not been applied for, or • That he/she is about to terminate health insurance coverage, or • That his/her health insurance coverage has lapsed.
2	Retain a copy of the DHCS 6172 with the case record.
3	Advise the beneficiary that private health insurance must be used prior to using Medi-Cal.
4	Tell the beneficiary that DHCS may require that Medi-Cal eligibles with existing third party coverage participate in HIPP if it is cost effective for the Department.
5	Mail the DHCS 6172 within five days to: Department of Health Care Services Medi-Cal Third Party Liability Branch HIPP Unit MS 4719 P.O. Box 997422 Sacramento, CA 95899-7422
6	After the County receives a confirmation notice from DHCS that the beneficiary has been accepted to the HIPP program, recompute the beneficiary's share of cost if necessary.

ACWDL 93-37

MPG Letter #681 (06/09)

C. Employer Group Health Plan

Effective January 1, 1991, OBRA 90 mandated that states pay health insurance premiums, deductibles, and co-payments for Medi-Cal recipients who are eligible for enrollment in an Employer Group Health Plan (EGHP) when it is cost effective.

ACWDL 93-37

In order to qualify for the EGHP program, the client must meet all the conditions listed in HIPP above, and the health insurance must be available through an employer.

ACWDL 91-94

The state may also pay only the premiums for a non-Medi-Cal eligible,

if the Medi-Cal eligible person's enrollment in the health plan is dependent on the non-Medi-Cal person's enrollment.

Required Worker Actions
The worker will:

Step	Action
1	Issue a DHCS 6172 if the applicant/beneficiary indicates: • He/she or a family member is employed and the employer related heath insurance is available, but has not been applied for. • He/she or a family member has health insurance but plans to drop it.
2	Enter the Health Plan information into the automated system, making sure to check the 'Are conditions present to require an EGHP referral present' checkbox.
3	Advise the client that if health insurance coverage is available at no cost to the beneficiary, the beneficiary must enroll.
4	If the worker learns that a beneficiary has withdrawn from mandatory enrollment in a state-paid health plan, the worker is to immediately notify DHCS by calling 1 (866) 298-8443. The state will verify the beneficiary's disenrollment and notify the County to discontinue Medi-Cal. Workers must not discontinue any Medi-Cal beneficiaries for unauthorized disenrollment in a state-paid health plan unless they are notified by the state.

ACWDL 95-71

DHCS Responsibilities for HIPP/EGHP

Step	Action
1	Review the referral information to determine if it is cost effective for the state to purchase the health insurance.
2	Notify the County if the state intends to approve or deny payment of health insurance.
3	Make payments to insurance carrier, employer or beneficiary as appropriate.
4	Update MEDS with the appropriate other health coverage code. If the Medi-Cal beneficiary is enrolled in either the HIPP or EGHP program, the source field will indicate either "HIPP" or "EGHP."
5	Re-evaluate premium payment cases periodically for cost-effectiveness, and notify the County if payment is discontinued.
6	Notify the County when it is verified that a beneficiary has

	discontinued enrollment in an approved health plan and request the County to give notice and discontinue Medi-Cal eligibility.

MPG Letter #681 (06/09)

D. Failure to Cooperate with HIPP/EGHP Requirements

Discontinuing Beneficiaries for Failure to Cooperate with HIPP/EGHP Requirements

ACWDL 93-37

When premium payment by HIPP/EGHP is found to be cost effective and the DHCS has started premium payments, the worker must discontinue Medi-Cal eligibility if the beneficiary terminates enrollment in the purchased health insurance without DHCS' approval. DHCS will send the beneficiary's worker a HIPP1 form notifying him/her that the beneficiary has canceled the state paid insurance. When the HIPP1 form is received, the worker will terminate the beneficiary's Medi-Cal eligibility with timely notice for failure to cooperate and send the beneficiary NOA DHS 6193.

Once the beneficiary receives the notice of action from the worker, he/she has the right to request a State Hearing regarding the discontinuance of benefits. The State will provide a position statement pertaining to DHCS testimony for the State Hearing.

MPG Letter #560 (08/04)

E. Denial of Enrollment or Termination of Participation by DHCS

ACWDL 95-82

Because a beneficiary's eligibility for and level of service under the Medi-Cal program is unaffected by a decision to deny or terminate participation in either the HIPP or EGHP program, CDSS Administrative Adjudications Division (AAD) will discontinue providing hearings on appeals for denials of enrollment or termination from the HIPP and EGHP programs.

Upon request for filing of an administrative hearing, AAD will deny scheduling an administrative hearing and notify the claimant that HIPP/EGHP cases which are denied from enrollment or terminated from either program are not appealable.

MPG Letter #337 (01/96)

APPENDIX A – SAN DIEGO COUNTY MANAGED HEALTH CARE PLANS

A. General

- Do not complete the DHS 6155
- Do not code as OHC persons enrolled in a managed care plan

B. San Diego Plans

For additional information, workers may contact the Healthy San Diego Information Line at (619) 515-6584.

MEDI-CAL MANAGED HEALTH CARE PLANS
Care 1st Health Plan (#167)
Community Health Group (#029)
Health Net (#068)
Kaiser Permanente (#079)
Molina Healthcare (#131)

MPG Letter # 681 (06/09)

APPENDIX B – HEALTH INSURANCE QUESTIONNAIRE

State of California – Health and Welfare Agency | Department of Health Services

HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. Use and attach a copy of your insurance policy, membership card, or any other aid to help complete this questionnaire. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. Additional instructions and information collection and access are on the reverse. If you have any questions about completing this form or require Spanish translation, call toll-free 1-800-952-5294 (7:30 a.m. to 5:00 p.m.).

COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING MEDICARE SUPPLEMENTS, PREPAID HEALTH PLANS/HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. HAVING PRIVATE HEALTH INSURANCE DOES NOT AFFECT YOUR MEDI-CAL ELIGIBILITY; HOWEVER, FAILURE TO REPORT OTHER HEALTH INSURANCE MAY BE CAUSE FOR TERMINATION OF YOUR MEDI-CAL ELIGIBILITY.

Case Name	FOR COUNTY USE ONLY	STATE USE ONLY	
	Worker Number	Verified By	
Case Address	Date	Date	Initials
	Worker Telephone Number ( )	Date	Initials
Initial Intake ☐ Redetermination ☐ HIPP ☐	*Optional* Dist. No.	Scope	CC #

SECTION I: Beneficiary Information ***LIST ALL PERSONS, INCLUDING UNBORNS, ON MEDI-CAL AND COVERED BY HEALTH INSURANCE POLICY***

OHC	Beneficiary Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	14-DIGIT MEDI-CAL NUMBER Co. Code	Aid Code	Case Number	FBU	Pers. No.
		– –							
		– –							
		– –							
		– –							
		– –							
		– –							

SECTION II: Health Insurance Information

1. What is the name and address of your health insurance company? Include street number, city, state, and ZIP. Do not use abbreviations.
   Name: _____
   Address: _____
   City, State, ZIP: _____
2. Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO/PPO) ☐ Yes ☐ No
3. Where do you send your claims?
   Name: _____
   Address: _____
   City, State, ZIP: _____
4. What is the full name, address, phone number, and SSA number of individual, employee, union member, or person to whom the insurance policy was issued?
   Name: _____ Social Security Number: _____
   Address: _____ Telephone Number: ( ) _____
   City, State, ZIP: _____ Absent Parent? ☐ Yes ☐ No
5. What is the policy number: _____
6. What are/were the dates of your policy? Beginning Date: _____ Ending Date (If applicable): _____
   ☐ Medical coverage available through employer, but has not been applied for.
7. Premium Amount: $_____ ☐ Monthly ☐ Quarterly ☐ Yearly
   How are premiums paid? ☐ By Insured to Insurance Carrier ☐ By Employer ☐ By Payroll Deduction
8. Give name of union; employer, group, organization, or school, address, and telephone number.
   Name: _____ Local or Group Number: _____
   Address: _____ Telephone Number: ( ) _____
   City, State, ZIP: _____
9. Does any covered beneficiary have an acute, chronic, or pre-existing illness that requires him/her to see a physician? ☐ Yes ☐ No
   If yes, please specify the illness: _____
10. Does your health insurance provide or pay for: (Check *all* that apply.)
    ☐ Hospital Outpatient (i.e., lab work/physical therapy) ☐ Prescription Drugs ☐ Long Term Care/Nursing Home
    ☐ Hospital Stays ☐ Dental Care ☐ Only specific illness (i.e., cancer)
    ☐ Doctor Visits ☐ Vision Care Type of illness: _____
11. Is the policy a Medicare Supplement? ☐ Yes ☐ No

Remarks:

"By signing this document, I hereby authorize the Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made on my behalf, to be used in determining whether the Department will pay my private health insurance premium."

Signature of Applicant	Home Telephone ( )	Work Telephone ( )	Date

RETURN COMPLETED FORM TO: RECOVERY BRANCH, P. O. BOX 997422, SACRAMENTO, CA 95899-7422

Original – State ***Yellow – County File*** ***Pink (Extra Copy – District Attorney-Beneficiary)***

DHS 6155 (10/90)

APPENDIX C – QUESTIONS FOR IDENTIFYING POTENTIAL OHC

TO EXPLORE WORK RELATED QUESTIONS	YES	NO
Does your employer (or a family member's employer) provide a health insurance plan?	If applicant/beneficiary currently HAS health insurance through an employer (or family member's employer), complete the DHS 6155 with the current insurance information. If insurance is available, but applicant/beneficiary has not enrolled, complete the DHS 6155 as an Employer Group Health Plan (EGHP) referral.	Do not complete the DHS 6155.
Did your former employer (or a family member's employer) provide health insurance coverage within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates.	Do not complete the DHS 6155.
Are you covered by your union's health insurance plan?	Complete the DHS 6155 with the health insurance information.	Do not complete the DHS 6155.
Were you covered by your union's health insurance plan within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates.	Do not complete the DHS 6155.
Does an absent parent (or the absent parent's employer) provide health insurance coverage for you and/or your children?	Complete the DHS 6155.	Complete the CA2.1 Medical Support Referral packet. Do not complete the DHS 6155.
Did an absent parent (or the absent parent's employer) provide health insurance coverage for you and/or your children within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates. Complete the CA2.1 Medical Support Referral packet also.	Complete the CA2.1 Medical Support Referral packet. Do not complete the DHS 6155.
Do you belong to any national organization (e.g., Foresters, Eagles, etc.)? Do you have health insurance through the organization?	Complete the DHS 6155 with the health insurance information.	Do not complete the DHS 6155.
Were you ever covered by insurance through any national organization (e.g., Foresters, Eagles, etc.) within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending rates.	Do not complete the DHS 6155.
APPLICANT/BENEFICIARY IS OVER AGE 65, RETIRED, OR DISABLED	**YES**	**NO**
Do you have Medicare coverage?	If applicant/beneficiary ONLY has	

	Medicare coverage and NO additional supplementary insurance plan, do not complete the DHS 6155.	
Do you have health insurance in addition to Medicare (such as a Medigap or Medicare supplement policy)?	Complete the DHS 6155 with the health insurance information. Inform person they do not need OHC.	Do not complete the DHS 6155.
Did you have health insurance in addition to Medicare within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates. Inform person they do not need OHC.	Do not complete the DHS 6155.
Do you have health insurance through a pension or retirement plan?	Complete the DHS 6155 with the health insurance information.	Do not complete the DHS 6155.
Did you have health insurance through a pension or retirement plan within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates.	Do not complete the DHS 6155.
TO EXPLORE OTHER INSURANCE POSSIBILITIES	**YES**	**NO**
Are you (or spouse or absent parent) enrolled in any educational program? If so, is health insurance available through a student health plan?	Complete the DHS 6155 with health insurance information.	Do not complete the DHS 6155.
Were you (or your spouse or absent parent) enrolled in any educational program that offered health insurance within the last three (3) years?	Complete the DHS 6155 and provide the insurance beginning and ending dates.	Do not complete the DHS 6155.
Are you (or your spouse or absent parent) in the military? DO NOT ASSUME THAT ONLY MEN HAVE SERVED IN THE MILITARY! If so, ask if military insurance is available to applicant/beneficiary and/or his/her dependent(s).*	If the applicant/beneficiary currently has insurance available through CHAMPUS, complete the DHS 6155 with the health insurance information. If insurance is available, but applicant/beneficiary has not enrolled, they should be instructed to contact the California Defense Enrollment Eligibility Reporting System (DEERS) Center at 1-800-334-4162 to find out how to go about enrolling for CHAMPUS benefits.	Do not complete the DHS 6155.
Were you (or your spouse or absent parent) in the military within the last three (3) years?*	Complete the DHS 6155 and provide the insurance beginning and ending dates.	Do not complete the DHS 6155.
*NOTE: Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a health benefits program		

for all seven uniformed services: The Army, Navy, Marine Corps, Air Force, Coast Guard Public Health Services, and National Oceanic and Atmospheric Administration. Covered persons include, but are not limited to: · Husbands, wives, and unmarried children of active-duty service members; · Retirees, their husbands or wives, and unmarried children; and · Unremarried husbands and wives and unmarried children of active duty or retired service members who have died.		
How have you paid for your medical care, prescriptions, and eyeglasses before now?	If the applicant/beneficiary indicates that these services have or are covered by insurance, complete the DHS 6155 with the health insurance information. Provide the ending insurance date if applicable.	

APPENDIX D – MEDS OHC CODES

MEDS OHC Indicator Codes and Their Corresponding Health Coverage Type (Found on Primary Medi-Cal/CMSP Information Segment in MEDS)

OHC Code	Health Coverage Type
9	Healthy Families
F	Medicare HMO
K	Kaiser HMO
C	CHAMPUS Prime HMO
P	Any Other PHP/HMO
V	Fee-for-Service Carriers (other than the above)
A	Pay-and Chase/Post Recovery
L	Any Dental Carrier
N	No other coverage

NOTE: When a client is identified as having OHC, a HMO or Cost Avoidance coding will be entered except if the client is living outside the health plan's service area, or needs to travel more than 60 miles or 60 minutes to receive services from the plan. In this situation, a "A" Post Recovery code will be used.

MEDS OHC Source Code Corresponding to the Process or Entity that Made the Change to the MEDS OHC Code (Found on Other Health Coverage Segment in MEDS)

OHC Source Code on MEDS	Process that Changed the OHC Code on MEDS
C	Updated from County Welfare Department
F	Updated from Healthy Families Vendor
H	Updated from Department of Health Services
M	MEDS assigned from the OHC update logic
R	Batch update from the Other Health Coverage Master File
S	Update from SSI/MEB
T	Tape to tape match with carriers and other sources

Eligibility Worker (EW)* Transaction Types and Its Effect on OHC Code on MEDS

County Transaction Type	OHC Code Submitted By County	Existing OHC Code on MEDS	Status of Health Insurance Segment	UPDATED OHC Code on MEDS	UPDATED OHC Source Code on MEDS
Immediate Need Transaction {EW15 and EW55 (SSI cases)}	N	Any (except 9)	Active or inactive segment(s)	N	C
EW20 or EW30	N	Cost avoidance (F, K, C, P or V)	One or more active segment	A	M
EW20 or EW30	N	Cost avoidance (F, K, C, P or V)	No active segment	N	C
EW15, EW55, EW20 OR EW30	Any (including N)	9	Active or inactive segment(s)	NO CHANGE (9)	NO CHANGE (F)

Types and Purpose of EW* Transactions

Transaction Type	Transaction Used To	Purpose of Transaction
EW15	Request Immediate Need Card Issuance	The EW15 transaction is used to request immediate need Medi-Cal identification card for the current or for any month within 12 months prior to the current MEDS month.
EW20	Add New Recipient Record	The EW20 transaction is used to add a new recipient to MEDS or to modify the eligibility information already on MEDS.
EW30	Modify MEDS Record (Individual)	The EW30 transaction is used to modify eligibility information, including current eligibility history and eligibility history for the prior twelve months of a recipient's MEDS record.
EW55	SSI/SSP Modify/ID Card Request	The EW55 is used when a SSI/SSP recipient is eligible on MEDS, but sex, birth date, other coverage, name and/or address is incorrect.

***** EW transactions are initiated via on-line requests submitted to the Family Resource Center MEDS clerks.

APPENDIX E – LIST OF HIGH COST MEDICAL CONDITIONS FOR HIPP PROGRAM

IF…	any of your clients have one of these MEDICAL CONDITIONS, or any other medical condition that requires frequent or costly treatment;	ACWDL I-97-15
AND…	the client has, or is eligible to apply for HEALTH INSURANCE;	
PLEASE…	Complete form DHCS 6172;	ACWDL 09-25
And if you have questions...	**CALL THE PREMIUM PAYMENT UNIT AT 1-866-298-8443**	

List of High Cost Medical Conditions

AIDS
Anorexia Nervosa
Aplastic Anemia
AIDS Related Complex (ARC)
Arteriosclerosis
Asthma
Brain Tumors
Bulimia
Burkitt's Tumor
Cancer (any site)
Chronic Gastric Ulcer
Cirrhosis of Liver
Cystic Fibrosis
Diabetes
Down's Syndrome
Ebstein's Anomaly
Emphysema
Epilepsy
Heart Disease
Hemiplegia
HIV infection
HIV related Pneumocystis Carinii Pneumonia (PCP)
Hodgkin's Disease
Hypoglycemia
Kaposi's Sarcoma
Kidney Disorders
Leukemia
Lymphomas
Lupus
Malignant Renal Disease
Multiple Sclerosis
Organ Transplant (any site)
Osteoporosis
Paralysis
Parkinson's Disease
Poliomyelitis
Pregnancy
Profound Retardation
Pulmonary Tuberculosis
Quadriplegia
Reticulosarcoma
Retinal Disorders
Scoliosis
Sickle-Cell Anemia
Spina Bifida

APPENDIX F – NOTIFICATIONS TO TPL REGARDING OHC

Methods	Type of Coverage			Time for Transaction
	New	Modify Existing[1]	Terminate Existing[2]	
OHC Related Automated Batch Transaction[6]	YES	YES	YES	2-60 calendar days[3]
Toll Free Telephone Line 1-800-952-5294	NO	YES	YES[5]	2 business days[4]
FAX 1-916-650-6585 1-916-650-6582	NO	YES	YES	4 business days[4]

[1] **Modifications** allowed include carrier contact information, scope of coverage, policy information. Counties must include the following information in order to initiate change(s):

- Client index number
- Date of birth

Note: Change of health coverage requires termination of old coverage on one day and reporting of new coverage on the following state business day.

[2] **Termination** of coverage requests from counties must include the following information in order to complete the process:

- Client index number
- Date of birth
- Insurance information
- Termination date
- Carrier code (if known)

[3] **Complete** and accurate transaction will be verifiable within two days; however, incomplete or inaccurate transactions can take up to 60 days.

[4] **Time for Transaction:** County responsibility to view in MEDS to verify the requested transaction has occurred. If it does not occur in allotted time, report the problem via e-mail.

[5] **For situations** where the presence of the OHC indicator is a barrier to care or when good cause exists.

[6] **CalWIN** splits OHC Coding and Health Insurance Information into two different windows. Actual OHC Coding is entered on the Health Care Information tab on the Collect Individual Attributes Detail Window. Information received from the DHS 6155 form is entered on the Display Health Coverage Summary Window.

APPENDIX G – HIPP/EGHP QUESTIONS & ANSWERS

Question #1 When the worker submits a HIPP or EGHP referral on the DHCS 6172 to DHCS, does that take the place of an application for either program? ACWDL 95-71

Response No. By submitting the DHCS 6172 to DHCS the worker has simply made a referral to DHCS for the HIPP or EGHP program. If DHCS determines after initial screening that the client appears to meet the requirements for either program, an application package will be sent directly to the client by SDHS.

Question #2 Will the HIPP or EGHP program pay for health insurance premiums that are past due?

Response No. The HIPP or EGHP program does not make payments for premiums that are past due.

Question #3 A Medi-Cal beneficiary's child (who is Medi-Cal eligible) has an absent parent who is supposed to pay for the child's health insurance, but does not. Can the HIPP or EGHP program pay the premiums, if the child has a high cost medical condition?

Response No. The HIPP or EGHP program cannot purchase or pay any health insurance premiums for a Medi-Cal beneficiary when an absent parent has been ordered by the court to provide medical support.

Question #4 What kind of documentation will the client need to submit to DHCS to be enrolled in either the HIPP or EGHP program and does the worker need to notify the beneficiary of the required documentation?

Response DHCS will notify the Medi-Cal beneficiary of information needed. For your information, the following documentation will be required:

- A fully completed and signed Health Insurance Premium Payment Application form (DHCS 6172).
- A copy of the health insurance policy (i.e., booklet, pamphlet, or brochure) describing the health plan's scope of benefits.
- A copy of a doctor's statement of diagnosis (signed and dated by a physician).

If the Medi-Cal beneficiary has health insurance:

- A copy of Explanation of Benefits (EOBs) from the health insurance company which details medical costs for a period of six months prior to the month of application.
- A copy of the latest premium payment notice or signed COBRA election form showing:
  - (a) Where the premium is to be sent;
  - (b) The exact amount of the premium;
  - (c) The date the premium is due; and
  - (d) The period of coverage (i.e., monthly, quarterly, etc.).

If the Medi-Cal beneficiary does not currently have health insurance but health insurance is available through an employer:

- A statement from the employer (or employer's insurance carrier) indicating the premium cost.
- **NOTE:** DHCS will obtain probable future medical cost information from the beneficiary's physician to determine cost effectiveness.

Question #5 The Medi-Cal beneficiary informs the worker that his/her health insurance lapsed within the last few months, and the beneficiary does have a medical condition. Can the worker still make a HIPP or EGHP referral?

Response If the beneficiary has a medical condition, but his/her health insurance lapsed within the last 60 days, submit a HIPP or EGHP program referral. If the case appears cost effective, DHCS will contact the insurance company and find out if it's possible to reobtain the insurance.

Question #6 Is there a phone number where the beneficiary can reach either the HIPP or EGHP program?

Response Yes. To reach the HIPP or EGHP program, the beneficiary can call toll free 1-866-298-8443, Monday through Friday, 7:30 A.M. to 5:00 P.M.

Question #7 Why would a Medi-Cal beneficiary want to retain their private health insurance while on Medi-Cal?

Response

- Beneficiaries can continue health care from their current medical provider.

- Beneficiaries can receive greater access to medical care by having private health insurance and Medi-Cal.
- The private health insurance carrier may pay for some services that Medi-Cal does not cover.
- Private health insurance copayments and deductibles may be paid by Medi-Cal. The provider bills the insurance first and then can bill Medi-Cal for the balance once the beneficiary has met his/her SOC. Providers cannot bill Medi-Cal beneficiaries for the cost of covered services.
- If a Medi-Cal beneficiary has private health insurance, a provider may be willing to treat them as a private pay patient. Some providers are not taking new Medi-Cal patients. The beneficiary's doctor may choose to continue the medical treatment if he/she knows that the beneficiary has private health insurance.
- If a Medi-Cal beneficiary drops the private health insurance because of Medi-Cal eligibility, it is often time very difficult or impossible to re-obtain private health insurance, particularly if the beneficiary has a pre-existing medical condition. The HIPP or EGHP program allows Medi-Cal beneficiaries to obtain/retain private health insurance, at no cost.

APPENDIX H – HIPP APPLICATION

Print Form

HEALTH INSURANCE PREMIUM PAYMENT APPLICATION

(See instructions for completing on reverse)

1. Name of applicant/Medi-Cal beneficiary
2. Social Security number
3. Telephone number ( )
4. Beneficiary's address
City
State
ZIP code
5. Name of insurance carrier
6. Insurance carrier's telephone number ( )
7. Premium billing location (where premiums are mailed)
City
State
ZIP code
8. Policy number
9. Current premium amount $
10. How often is it paid (check which applies)
☐ Monthly ☐ Quarterly ☐ Other:
11. Current policy status (check and fill in date, if applicable)
COBRA ☐ Yes ☐ No ☐ Policy is paid through: ☐ Policy lapsed on:
12. Type of coverage your insurance provides (check all that apply)
☐ Hospital stays
☐ Hospital outpatient (i.e., lab work or physical therapy)
☐ Doctor visits
☐ Prescription drugs
☐ Vision care
☐ Dental care
☐ Long Term Care (LTC)
13. Name of policyholder
14. Policyholder's Social Security number
15. Policyholder's address
City
State
ZIP code
16. Policyholder's telephone number. ( )
17. Is the policy holder court ordered to provide the medical insurance? ☐ Yes ☐ No
18. Is the policy a Medicare Policy? ☐ Yes ☐ No
19. How are the insurance premiums currently paid (check which applies)
☐ Paid ENTIRELY by employer
☐ Paid by policyholder directly to insurance carrier
☐ Paid by policyholder through payroll deduction
☐ Other:
20. Name and Social Security Number of other family members covered by Medi-Cal *AND* the private insurance listed in item 5:

Name	Social Security Number

21. Policyholder's employer
22. Employer's telephone number ( )
23. Employer's address
City
State
ZIP code
24. Does anyone listed on this application have a high-cost medical condition that requires a physician's treatment? If so, list the name and type of illness (use additional paper if necessary).

Name | Illness | Name | Illness

IMPORTANT: As a condition of eligibility, all Medi-Cal beneficiaries shall assign rights to medical insurance, support, or other third-party payments to the Medi-Cal program and shall cooperate with the California Department of Health Care Services in obtaining medical support or payments. The assignment of rights to benefits is effective only for services paid for by the Medi-Cal program. Assignment of medical rights allows the California Department of Health Care Services to recover funds from health insurance companies or funds when the Medi-Cal program pays for medical services, which should have been billed to other health insurance coverage. Please note that in order to comply with the Federal Privacy Act (42USC, Section 552a) your Social Security Number and any information you provide may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Under Welfare and Institutions Code, Section 14100.2, any submitted information is considered confidential and disclosed only as necessary for Medi-Cal program administration purposes.

AUTHORIZATION: "I hereby authorize the California Department of Health Care Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, which may be used in determining if the California Department of Health Care Services will pay health insurance premiums for continued coverage."

Signature of Medi-Cal Beneficiary
Date

INSTRUCTIONS FOR COMPLETING THE HEALTH INSURANCE PREMIUM PAYMENTAPPLICATION FORM DHCS 6172

The following instructions are to be used in completing the Health Insurance Premium Payment application. PLEASE PRINT THE INFORMATION.

1 Enter your full name.

2 Enter your nine-digit Social Security number.

3 Enter your complete daytime telephone number, including area code. If you do not have a telephone number, please enter a message telephone number in the telephone number box and indicate, "message."

4 Enter your complete street address, city, state, and zip code.

5 Enter the name of your current health insurance carrier.

6 Enter the telephone number, including area code, of your health insurance carrier.

7 Enter the complete street address, city, state, and zip code where your premiums are mailed.

8 Enter your health insurance policy number.

9 Enter your current health insurance premium amount.

10 Indicate how often you pay your health insurance premiums by checking the appropriate box.

11 Indicate if your health insurance is being paid through COBRA by checking the yes or no box. Also, indicate the date your policy is paid through. If your policy has lapsed within the last 90 days, indicate the date the policy lapsed.

12 Indicate, by entering a checkmark in the appropriate box(es), the medical services that are covered by your health insurance policy.

13 Enter the full name of the insured/policyholder. This is the name of the person to whom the policy was issued.

14 Enter the nine-digit Social Security number of the policyholder.

15 Enter the complete street address, city, state, and zip code of the policyholder.

16 Enter the policyholder's daytime telephone number, including area code. If the policyholder does not have a telephone number, please enter a message telephone number in the telephone number box and indicate "message."

17 Indicate if the policy holder is court ordered to provide the insurance for the applicant.

18 Indicate if the policy is a Medicare policy.

19 Indicate, by entering a checkmark in the appropriate box, how the insurance premiums are currently paid.

20 Enter the complete name and nine-digit Social Security number of other family members that are covered by Medi-Cal AND the health insurance policy listed in item 5.

21 Enter the full name of the policyholder's employer.

22 Enter the telephone number of the policyholder's employer, including area code.

23 Enter the full street address, city, state, and zip code of the policyholder's employer.

24 Enter the name and type of illness for persons listed in item 18 who have a high-cost medical condition.

Signature section: Please sign and enter the date when you have completed this form.

Mail this form to: Department of Health Care Services, HIPP Program, MS 4719, PO Box 997422, Sacramento, CA 95899-7422. If you have any questions about completing this form, call toll free 1-866-298-8443 (California only), 8:00 a.m.–5:00 p.m., Monday through Friday.