46. Other Health Coverage (OHC)

46.1 Introduction [50761]

46.1.1 Background

State regulations require that Medi-Cal beneficiaries report and utilize any other health insurance that is available. Federal law prohibits Medi-Cal from paying for services which are covered by the client's private or group health insurance or health plan. The California Department of Health Care Services (DHCS) Third Party Liability and Recovery Division (TPLRD) has implemented electronic health data exchanges among the health care providers, consumers of health care and government agencies to obtain other health coverage information for Medi-Cal beneficiaries through an automated data match process.

This chapter discusses the required identification, reporting and coding of Other Health Coverage (OHC).

46.1.2 Definition

OHC is defined as benefits for health related services or entitlements for which a Medi-Cal beneficiary is eligible under any:

- Private, group or indemnification insurance program.
- Other state or federal medical care program.
- Other contractual or legal entitlement.

46.2 Client Responsibility

46.2.1 Reporting

All Medi-Cal clients have the responsibility to report:
Other Health Coverage (OHC)

- Current OHC information. This includes not only current health insurance, but also health insurance which is available, but not applied for.

- The availability of employer related health benefits.

- OHC changes within ten days (for example, termination, lapses, or a different insurance carrier).

- OHC information to their doctors and other health care providers.

The beneficiary must utilize private health insurance prior to using Medi-Cal.

Note:
If the beneficiary refuses to cooperate in the State's purchase of health insurance under the HIPP program, when it is found to be cost effective, DHCS may decline payment for medical services which would otherwise be covered by the insurance policy.

46.2.2 Fraud Referrals

If the EW suspects that a Medi-Cal beneficiary is withholding information about OHC, the client's name, CIN and any available OHC information must be communicated DHCS in one of the following ways:

Department Of Health Care Services
PAU, MS 2200
P.O. Box 977413
Sacramento, CA 95899-7413

DHCS Medi-Cal Fraud Hotline:
1-800-822-6220

E-mail: stopmedicalfraud@dhcs.ca.gov

Online complaint form:
https://apps.dhcs.ca.gov/AutoForm2/default.aspx?af=1828
46.3 EW Responsibility

46.3.1 Informing

EWs must inform Medi-Cal applicants and beneficiaries that:

• Reporting OHC does not interfere with their eligibility for or use of Medi-Cal benefits.

• If health insurance coverage is available from any source, at no cost to the beneficiary, the applicant/beneficiary must enroll. If the applicant/beneficiary fails to cooperate by not enrolling in the plan, the EW must deny or discontinue Medi-Cal eligibility.

• Employer related health benefits which are available to an individual must be reported. If there is no cost, the benefits must be applied for and retained. The Medi-Cal program may pay the health insurance premiums if it is determined to be cost effective. [Refer to “Health Insurance Premium Payment (HIPP) Program,” page 46-15.]

• Any health insurance payments received for health care services paid by Medi-Cal must be reported and repaid.

• Due to the confidentiality of Minor Consent Services, Medi-Cal will not report OHC nor bill private insurance carriers for such services.

Note:
Federal law requires that EWs inform Medi-Cal beneficiaries and applicants that they are not required to purchase Medigap insurance.

46.3.2 Identification

EWs must ask applicants and recipients if they have other health insurance when:

• Interviewing CalWORKs or Medi-Cal only applicants during the Intake process.

• Completing a CalWORKs or Medi-Cal only redetermination.

• A CalWORKs or Medi-Cal only client is or was recently employed.
Other Health Coverage (OHC)

- A CalWORKs or Medi-Cal only client obtains, loses or changes employment.

- It is reported that an absent parent is employed, obtains, loses or changes jobs (OHC may be available for the dependents).

- Child support payments are being made, as employment of the absent parent is strongly indicated.

- A client reports veteran status, military service or union membership of a family member or an absent parent.

- The client or absent parent is a student (who may have insurance through a school health plan).

- Work history indicates national organization membership (such as the American Association of Retired Persons or National Retired Teachers Association, which offer health plans).

- Earnings statements indicate health coverage deductions.

- Other evidence indicates the client may have other health insurance.

46.3.3 EW Actions

EWs are required to determine the availability of other health coverage by reviewing the Statement of Facts and asking key questions.

The chart below describes the actions EWs must take to identify OHC:

<table>
<thead>
<tr>
<th>If the Client...</th>
<th>Then the EW Must...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicates either on the Statement of Facts or verbally that other health insurance is available,</td>
<td>Interview the client further to determine if the health insurance policy is one listed [Refer to “Insurance Policies Requiring OHC Identification,” page 46-10.]</td>
</tr>
</tbody>
</table>
| Indicates the absent parent is: employed, was recently employed, retired, serving in the military, a veteran, a union member, or a student, | • Ask the client additional questions to determine if other health insurance is available.  
• Review information on the “Employment Questionnaire” (CSF 22), if used, to determine if OHC is available from a new job. |
46.3.4 Good Cause

There may be instances where the applicant/recipient may have other health coverage available but is unable to access this coverage. The EW must explore good cause and obtain a signed statement about the situation. Good cause exists when:

- There are geographic barriers to accessing the health coverage. OHC is considered unavailable when the health plan is limited to a specific geographic service area and the beneficiary lives outside that area or the health plan requires use of specified provider(s) and the beneficiary lives more than 60 miles or 60 minutes travel time from the specified provider(s).

- There are domestic abuse issues. [Refer to “Removal of OHC Codes for Victims of Domestic Violence,” page 46-27]

- Beneficiary never had a plan with a carrier, yet HIS reset an OHC record that was removed during a previous month match.

If good cause exists, the EW must follow the steps indicated on section 46.3.6 on page 8, “Removing OHC,” page 46-8 to remove OHC.

The OHC Processing Center will set the OHC record so it is bypassed during claims adjudication or put the beneficiary on a “no carrier match list” to prevent the next month OHC match from resetting the Health Insurance System (HIS) record in MEDS.

Note:
DHCS cannot correct or remove the health insurance records that come through the Local Child Support Agency (LCSA) OHC data match. In these situations, the EW should work with the LCSA to have the OHC record removed from the CS Administration OHC data match. To communicate with
the LCSA, staff may complete and send the “Social Services Agency/Local Child Support Agency Communication Form” (SCD 1603) or call 866-901-3212.

### 46.3.5 Reporting OHC Changes or New Policy

EWs must update CalWIN when a new OHC coverage policy is reported or there are subsequent changes to the current health coverage information.

The chart below describes the types of OHC changes and the EW actions:

<table>
<thead>
<tr>
<th>OHC Change</th>
<th>EW Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Client's name</td>
<td>Update the Collect Individual Attributes Detail and the Collect Health Care Coverage Detail windows with the proper OHC information, as needed.</td>
</tr>
<tr>
<td>• Address</td>
<td></td>
</tr>
<tr>
<td>• Carrier contact information</td>
<td></td>
</tr>
<tr>
<td>• Scope of coverage</td>
<td></td>
</tr>
<tr>
<td>• Policy information</td>
<td></td>
</tr>
<tr>
<td>• Dependents</td>
<td></td>
</tr>
<tr>
<td>• Gender</td>
<td></td>
</tr>
</tbody>
</table>

**Different OHC Policy**

- To report termination of old OHC, refer to “Removing OHC,” page 46-8.
- Update CalWIN with the proper OHC information on the Collect Individual Attributes Detail, the Collect Health Care Coverage Detail and the Collect Insured Individual Detail windows.

**Additional or New policy**

Update CalWIN with the new OHC information on the Collect Individual Attributes Detail and the Collect Health Care Coverage Detail windows.

**If the Additional or new policy...**

<table>
<thead>
<tr>
<th>Then the EW...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is NOT of the following:</td>
</tr>
<tr>
<td>• Aetna</td>
</tr>
<tr>
<td>• Anthem Blue Cross</td>
</tr>
<tr>
<td>• Arcadian Health Plan</td>
</tr>
<tr>
<td>• Blue Shield of California</td>
</tr>
<tr>
<td>• Care 1st Health Plan</td>
</tr>
<tr>
<td>• Central Health Plan of California, Inc.</td>
</tr>
<tr>
<td>• Chinese Community Health Plan</td>
</tr>
<tr>
<td>• Easy Choice Health Plan</td>
</tr>
<tr>
<td>• GEMCare Health Plan</td>
</tr>
<tr>
<td>• Health net of California, Inc.</td>
</tr>
<tr>
<td>• Health Net Life Insurance</td>
</tr>
</tbody>
</table>
Reminder:
DHCS receives automated data exchanges from various sources; therefore, it is not necessary complete the online form to report new or changes in OHC coverage.

<table>
<thead>
<tr>
<th>OHC Change</th>
<th>EW Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health Net Community Solutions, Inc.</td>
<td></td>
</tr>
<tr>
<td>• Inter Valley Health Plan</td>
<td></td>
</tr>
<tr>
<td>• Kaiser Foundation Health Plan, Inc.</td>
<td></td>
</tr>
<tr>
<td>• MD Care Health Plan</td>
<td></td>
</tr>
<tr>
<td>• PacifiCare of California</td>
<td></td>
</tr>
<tr>
<td>• SCAN Health Plan</td>
<td></td>
</tr>
<tr>
<td>• Social Services Coordinators, LLC</td>
<td></td>
</tr>
<tr>
<td>• Unicare</td>
<td></td>
</tr>
<tr>
<td>• United Healthcare Services, Inc.</td>
<td></td>
</tr>
<tr>
<td>• Wellcare Health Plan, Inc.</td>
<td></td>
</tr>
</tbody>
</table>

Reminder:
The EW's Name, Phone Number and E-mail Address must be entered in the "Submitter's Contact Information" section.
46.3.6 Removing OHC

A request to remove the OHC code from MEDS must be made when there is termination of coverage, the policy will or has lapsed, or the beneficiary does not have the coverage identified through other sources (e.g. DHCS data match or health insurance from an absent parent on the HIAR screen).

Verification

In order to ensure that Medi-Cal is the payer of last resort, termination of OHC must be verified prior to removing the OHC code from MEDS for beneficiaries whose OHC has ended or who never had OHC.

Acceptable verifications include:

- A payroll or pension check stub which shows that health insurance deductions have stopped.

- An Explanation of Benefits from the insurance carrier showing the policy termination date.

- A termination letter from the health insurance carrier or employer showing the policy termination date.

**Note**: If the termination letter indicates COBRA eligibility and the beneficiary has a high cost medical condition, refer the client to the Health Insurance Premium Payment program. [Refer to “Health Insurance Premium Payment (HIPP) Program,” page 46-15.]

- A “General Affidavit” (SCD 101 or CSF 2) signed by the client or representative stating he/she no longer has, or never had the OHC. The affidavit must include the coverage termination date, if known. The affidavit may be used when an erroneous OHC code appears on a beneficiary's Medi-Cal record after DHCS conducts a data match with an insurance carrier, domestic violence situations, or in any other situation where the client cannot verify termination. The affidavit may also be used when a custodial parent or guardian cannot verify termination of an absent parent's insurance.

Scan the verification of OHC termination in IDM under F-1.

**Note**: Do NOT fax or send the verification to DHCS, however do ensure it is scanned into IDM.
OHC Termination/Removal Process

To report termination or request removal of OHC the following steps must be taken:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Enter the correct information and insurance termination date (if applicable) on the Collect Individual Attributes Detail and the Collect Health Care Coverage Detail windows.</td>
</tr>
<tr>
<td>2.</td>
<td>Inform DHCS to remove the OHC MEDS indicator. To inform DHCS to remove the OHC code from MEDS, complete the online form available on the California Department of Health Care Services (DHCS) website or call 1-800-541-5555 (press 2 for beneficiary). The online request MUST include the following information:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Online Form Fields</th>
<th>What to Enter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal No.</td>
<td>CIN of the beneficiary</td>
</tr>
<tr>
<td>Last Name, First Name, Date of Birth</td>
<td>Name and DOB of the beneficiary</td>
</tr>
<tr>
<td>Remove all active Other Health Coverage</td>
<td>Yes</td>
</tr>
<tr>
<td>Carrier Code</td>
<td>If known, enter code; otherwise, leave blank</td>
</tr>
<tr>
<td>Carrier Name</td>
<td>Name of the OHC carrier</td>
</tr>
<tr>
<td>Policy Stop Date</td>
<td>Date needed to terminate the OHC code</td>
</tr>
<tr>
<td>Note: If no date is provided, DHCS will terminate the record effective the last day of the previous month.</td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td>Reason why the OHC needs to be terminated (e.g. Good Cause- Domestic violence victim)</td>
</tr>
<tr>
<td>Submitter’s Name</td>
<td>Eligibility Worker’s Name</td>
</tr>
<tr>
<td>Phone Number</td>
<td>Eligibility Worker’s Phone Number</td>
</tr>
<tr>
<td>E-mail Address</td>
<td>Eligibility Worker’s e-mail address</td>
</tr>
<tr>
<td>3.</td>
<td>For website submissions, DHCS will send a generic e-mail to confirm that the request has been entered. The EW must check MEDS to verify that the changes are complete and correct.</td>
</tr>
</tbody>
</table>
46.4 Insurance Policies Requiring OHC Identification

The following is a list of insurance policies that provide other health coverage benefits. The OHC information must be entered in CalWIN for persons who have these policies.

Cancer Only

Policies that cover medical expenses related to cancer treatment only.

TRI-CARE (formerly known as CHAMPUS)

TRI-CARE pays for the health care of retired members and dependents of active and retired members of the Armed Forces under 65.

Dental Only

Policies that cover expenses related to dental work.

Employment-Related

Health insurance provided to employees and their dependents. This could include health insurance through union membership, or membership in a national organization, fraternity or trust fund.

ERISA (Employee Retirement Income Security Act)

Any health insurance that is offered through a trust fund operating under the authority of the U.S. Department of Labor (for example, carpenters, pipefitters, plumbers).

Group Health

Policies that provide health benefits to persons employed by or affiliated with an employer, union, association or organization.
Health

Policies that cover hospital expenses, surgical expenses, routine medical expenses, or major medical.

Hospital

Policies that cover expenses incurred during hospitalization.

Indemnity

Policies that pay benefits in the form of cash payments. These benefits are paid to the insured instead of to the provider.

Long-Term Care

Policies that cover long term care expenses (for example, custodial care, intermediate care, skilled nursing care).

Major Medical

Policies that cover medical expenses over and above those expenses covered by a basic benefit plan.

Medical Support

An absent parent may be required to provide medical insurance premium payments or be responsible for a portion of medical bills; or, if employed, may be required to include dependent children in the medical insurance plan provided by the employer.

Medicare Supplemental

Policies which pay that portion of Medicare covered services which Medicare does not pay.

PHP/HMO

A Prepaid Health Plan (PHP) or Health Maintenance Organization (HMO) which provides a wide range of comprehensive health care services for persons insured by the policy or plan. Services are provided by plan designated providers at designated facilities.
Medi-Cal Handbook

Other Health Coverage (OHC)

Prescription

Policies that cover prescribed drugs only.

Student Health

Health insurance offered through an educational institution for enrolled students.

Surgical

Policies that cover surgery-related expenses only.

Vision

Policies that cover vision-related expenses only.

46.5 COBRA

46.5.1 Continuation of Benefits

Federal law (Public Law 99-272), also known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, provides for the continuation of private health insurance coverage in the following situations:

- Death of an employee (the spouse and dependent children are covered by COBRA).

- Divorce or legal separation (the divorce decree must include provision for this insurance).

- The Medicare-ineligible spouse of a retiring worker.

- Termination of employment or reduction in hours.

- A dependent child ceases to be an eligible dependent.
46.5.2 Employers Affected

COBRA provisions apply to private employers with 20 or more workers and to state and local government health plans, and can continue for three years after one of the above changes occur.

46.5.3 Notification Requirements

Persons who wish to continue the coverage must notify the employer within 60 days of the date of the work status change. This law will not help once the 60-day limit has ended.

46.5.4 Payment of Premium

Payment must be made by the employee or the affected individual for the full monthly premium (both the employer and the employee portions), plus a two percent administrative fee. Medi-Cal may pay the employee's share of the premium through the HIPP program. [Refer to “Health Insurance Premium Payment (HIPP) Program,” page 46-15]

46.5.5 Termination of Coverage

COBRA coverage ends:

• If the premium is not paid.
• If eligibility for another health plan is established through:
  • New employment
  • Remarriage
  • Medicare
• If the employer ends group health coverage for all workers.

46.6 Insurances Not Included as OHC

46.6.1 Unavailable

In CalWIN, Other Health Coverage is coded “N” when OHC is unavailable. Unavailable OHC includes:
Other Health Coverage (OHC)

- Any coverage to which a child may be entitled, if the child is applying for Minor Consent Services.

- Coverage to which a child may be entitled when:
  
a. The parent or guardian refuses to provide the necessary insurance information due to a “good cause” claim in the medical referral process. [Refer to Common-Place Handbook, “Good Cause Determinations [EAS 82-512, 82-514, CCR 50175, 50771.5, 50185],” page 31-13]

b. The absent parent cannot be located, and

  • The child is applying for Medi-Cal independently and would be in a separate MFBU from the custodial parent or guardian, or

  • The child is applying for Medi-Cal independently and has no custodial parent or guardian (e.g., child under age 18 applying as an adult).

Note:

Any private PHP/HMO plan which is limited to a specific geographical service area and the beneficiary must travel more than 60 miles or 60 minutes to receive care will be coded as “N.”

46.6.2 Other

CalWIN OHC coding is not required when a client has only the following benefits:

- Accident benefits
- Automobile, Burial, and Life Insurance benefits
- Casualty Workers Compensation benefits
- Disability benefits
- Medicare
- Healthy Kids
- Veteran's Administration (VA) benefits
- Coverage under a PHP or HMO which the client has chosen as a Health Care Option (HCO).
Other Health Coverage (OHC)

• Coverage under one of the mandatory two-plan model managed care plans: 
  Anthem Blue Cross of California or Santa Clara Family Health Plan.

46.7 Health Insurance Premium Payment (HIPP) Program

46.7.1 Definition

Whenever it is cost effective, DHCS may elect to pay health insurance premiums 
on behalf of Medi-Cal beneficiaries. The objective of the Health Insurance Premium 
Payment (HIPP) program is to reduce Medi-Cal expenditures by continuing to pay a 
beneficiary's health insurance coverage when the cost of the premium would be 
less than the cost of Medi-Cal benefits.

Note: 
The Employer Group Health Plan (EGHP) was combined with the HIPP 
Program.

46.7.2 HIPP Qualifications

A person qualifies for application to HIPP when all of the following requirements are 
met:

• There is current Medi-Cal eligibility.

• The beneficiary is not Medicare eligible.

• The premiums are not the court ordered responsibility of the absent parent.

• The applicant or family member must have a high-cost medical condition.

• The expected Medi-Cal Program savings are at least more than the amount of 
  the premium cost.

• There is current health insurance coverage, COBRA continuation, a conversion 
  policy in effect or available, or coverage available through another source.

• For COBRA applicants, there is enough time for the State to process the 
  application and get the premium paid to meet insurance company deadlines.
Other Health Coverage (OHC)

A timely application is defined as follows:

<table>
<thead>
<tr>
<th>When Coverage Is Under</th>
<th>And HIPP Application Is Made Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>COBRA continuation</td>
<td>30 days of the insurance termination date.</td>
</tr>
<tr>
<td>A conversion policy</td>
<td>20 days of the insurance termination date.</td>
</tr>
</tbody>
</table>

- The policy must cover the beneficiary’s high cost medical condition.
- The policy was not issued through the California Major Risk Medical Insurance Board.
- There is no enrollment in a Medi-Cal related pre-paid health plan, County Health Initiative or Geographic Managed Care Plan.
- There is no retro or past due payments due on the policy.

**Note:**
Eligibility for HIPP begins the month the application is received.

**46.7.3 EW Action**

The “HIPP Application Form - Fillable” form (located at: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx) acts as a referral to the HIPP Program. Follow the online instructions to complete it. The online form must be completed by the applicant/beneficiary, or the EW.

**Completing the online application**

The online HIPP application must include the following information:

<table>
<thead>
<tr>
<th>Online Form Fields</th>
<th>What to Enter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal BIC Number</td>
<td>CIN of the beneficiary</td>
</tr>
<tr>
<td>Name (last, first middle)</td>
<td>Name of the beneficiary</td>
</tr>
<tr>
<td>Address (street, apartment no.)</td>
<td>Complete address of the beneficiary</td>
</tr>
<tr>
<td>City, State, Zip Code</td>
<td></td>
</tr>
<tr>
<td>Contact Telephone Number</td>
<td>10-digit telephone number of the beneficiary</td>
</tr>
<tr>
<td>E-Mail Address</td>
<td>The online application submission process requires a valid e-mail address. If the EW is completing the application for the client, the EW’s e-mail address should be entered</td>
</tr>
</tbody>
</table>
### Other Health Coverage (OHC)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently on Medicare?</td>
<td>Yes or No</td>
</tr>
<tr>
<td>Is This a COBRA policy?</td>
<td>Yes or No</td>
</tr>
<tr>
<td>If Yes, please enter the policy start and stop dates:</td>
<td></td>
</tr>
<tr>
<td>• Start Date</td>
<td></td>
</tr>
<tr>
<td>• End Date</td>
<td></td>
</tr>
<tr>
<td>How are insurance premiums currently paid:</td>
<td>Must select the appropriate method of payment</td>
</tr>
<tr>
<td>• Paid by policyholder directly to insurance carrier</td>
<td>If “Other” is selected, must provide explanation in free-form text box.</td>
</tr>
<tr>
<td>• paid by policyholder through payroll deduction</td>
<td></td>
</tr>
<tr>
<td>• Other</td>
<td></td>
</tr>
<tr>
<td>Insurance Company</td>
<td>Name of the OHC Insurance (e.g. Kaiser)</td>
</tr>
<tr>
<td>Insurance Company Telephone Number</td>
<td>Business telephone number for the OHC Insurance company</td>
</tr>
<tr>
<td>Policyholder Name</td>
<td>Name of person who is the holds the OHC coverage policy (e.g. if insurance provided by employer, name of the employee)</td>
</tr>
<tr>
<td>Policy holder Address</td>
<td></td>
</tr>
<tr>
<td>City State, Zip Code</td>
<td></td>
</tr>
<tr>
<td>Policy Number</td>
<td>OHC policy number</td>
</tr>
<tr>
<td>Group Number</td>
<td>OHC group number</td>
</tr>
<tr>
<td>Current Premium Amount</td>
<td>Out of pocket costs for insurance</td>
</tr>
<tr>
<td>Number of individuals covered under this policy</td>
<td>total number of individuals who have coverage</td>
</tr>
<tr>
<td>File Upload</td>
<td>This section requires that the following documents be uploaded with the application:</td>
</tr>
<tr>
<td></td>
<td>• Explanation of Benefits- at least 1 year of medical and pharmaceutical services</td>
</tr>
<tr>
<td></td>
<td>• Insurance Rate Sheet Breakdown or Current Premium Statement</td>
</tr>
<tr>
<td></td>
<td>• payee Data record</td>
</tr>
<tr>
<td></td>
<td>• HIPP Forms (located on the main HIPP website)</td>
</tr>
<tr>
<td></td>
<td>•DHCS 9114 (if applicable)</td>
</tr>
<tr>
<td></td>
<td>•DHCS 9119</td>
</tr>
<tr>
<td></td>
<td>•DHCS 9120</td>
</tr>
<tr>
<td></td>
<td>•DHCS 9121</td>
</tr>
</tbody>
</table>

**Reminder:**
It is vital that all potential HIPP applications be sent immediately. Timing in making the first premium payment to the insurance carrier is critical to the carrier's obligation to accept coverage.
Although it may appear that a client qualifies for HIPP, DHCS may/may not approve the HIPP application.

### 46.7.4 DHCS Responsibility

DHCS (HIPP Program) will:

- Process the HIPP Application.
- Initiate premium payments to the insurance carrier, employer, or beneficiary, if approved. (The premium payment is paid beginning the month the HIPP application is received).
- Update MEDS with appropriate OHC code.
- Reevaluate the premium payment cases annually. The EW and the client will be notified of any changes.

### 46.7.5 HIPP Approved

EWs must delete the private health insurance premium in CalWIN (allowing for a 10-day notice if the SOC will be increased) and check to make sure the OHC is already entered in CalWIN and that MEDS is coded correctly.

**Note:**

There are no California Department of Social Services Administrative Adjudications Division hearings on appeals for denial of enrollment to the HIPP Program as of January 1, 1996.

### 46.7.6 Client Disenrolls from OHC voluntarily

If the EW learns that the client has voluntarily disenrolled from OHC for which the State is paying the premium, notify DHCS immediately by calling 1-866-298-8443.

DHCS takes the following action:

- After disenrollment is verified, DHCS notifies the EW to discontinue the client from Medi-Cal with a timely 10-day Notice of Action (NOA).

Upon notification, the EW shall:
• Discontinue the person responsible for withdrawing from the State-paid health plan,

• Issue a timely discontinuance NOA, and

• Treat the discontinued person as an ineligible member of the MFBU. Medi-Cal benefits shall continue for members of the family unit who are unable to enroll on their own behalf.

46.8 HIPP Questions and Answers

46.8.1 Referral Process

Q. How do I make a referral if a Medi-Cal beneficiary currently has health insurance (private or employer related) and has a high cost medical condition?

A. Assist the beneficiary in completing the online application (http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx) because it might be cost effective for the HIPP Program to pay the premiums.

46.8.2 High Cost Medical Condition

Q. Is it required that a beneficiary have a high cost medical condition in order to qualify for the HIPP program?

A. In order to meet the cost effectiveness criteria, the expected Medi-Cal program savings are at least more than the amount of the premium cost. In order to meet this, someone receiving Medi-Cal in the family must have a high cost medical condition.

46.8.3 Approval

Q. How will I find out if one of my clients has been enrolled into HIPP?

A. DHCS will notify the county that the client has been enrolled. You can also find out by viewing the beneficiary’s Health Insurance Action Request (HIAR), Health Insurance Record (HIS) screens. If the Medi-Cal beneficiary is enrolled in the HIPP, the “Source” field will indicate “HIPP.” [Refer to “HIAR - Health Insurance Action Request,” page 1-72].
46.8.4 Past Due Premiums

Q. Will the HIPP program pay for health insurance premiums that are past due?

A. No, the HIPP program does not make payments for past due premiums paid prior to application approval.

46.8.5 Non-Medi-Cal Family Member

Q. Can the HIPP program pay insurance premiums for a family member who is not receiving Medi-Cal?

A. The client must be eligible for Medi-Cal.

46.8.6 Requirement to Apply

Q. Is my client required to apply for the HIPP program?

A. Section 50763(a)(1) of the California Code of Regulations requires a Medi-Cal beneficiary to apply for, and/or retain any available health insurance that is provided at no cost. When premium payment by the HIPP Program is found to be cost effective and DHCS has started premium payments, the county will be notified by DHCS to discontinue Medi-Cal eligibility if the beneficiary terminates enrollment in the health insurance without DHCS' approval.

46.8.7 Insurance Lapsed

Q. The Medi-Cal beneficiary informed me that his/her health insurance lapsed within the last few months, but the beneficiary does have a medical condition. Can I still make an HIPP referral?

A. If the beneficiary has a medical condition, but the beneficiary's health insurance lapsed within the last 60 days, submit an HIPP Program application. If the case appears cost effective, DHCS will contact the insurance company and find out if it is possible to reobtain the insurance.
46.9 OHC Identification by DHCS

46.9.1 DHCS

The Department of Health Care Services (DHCS) currently receives OHC data from over 20 health insurance carriers, the Department of Child Support Services, the Social Security Administration, California Children's Services, and other automated system.

46.9.2 Discrepancies

When DHCS discovers a discrepancy, MEDS is updated with the insurance information and scope of coverage codes (cost avoidance OHC codes).

Affected beneficiaries are sent a letter explaining cost avoidance and informed that their providers must bill the other health coverage carrier prior to billing Medi-Cal. Beneficiaries are instructed to contact their EW if they no longer have the coverage.

Both beneficiaries and EWs who have further questions about the health insurance coverage may call the DHCS, OHC Section's toll-free number, 1-800-541-5555, who will answer health insurance related questions and assist in resolving problems.

If there is a discrepancy, a County Eligibility Worker Alert (CEWA) will be generated by DHCS to advise the EW that DHCS has changed the beneficiary’s OHC on MEDS.

46.10 OHC Billing Methods

46.10.1 General

When beneficiaries have health insurance coverage, providers have different billing requirements depending on the type of OHC code appearing on the Medi-Cal record.
46.10.2 Cost Avoidance

This type of OHC code requires the provider to bill the other health coverage carrier prior to billing Medi-Cal. An Explanation of Benefits (EOB) from the private coverage carrier, indicating either a denial of payment or partial payment, must be attached to the provider’s claim.

Exception:
- The provider is not required to bill the private carrier first when a person in long-term care has a cost avoidance type of coverage.

- Federal law mandates exceptions to cost avoidance when claims are for prenatal or preventive pediatric services. In these instances, DHCS contracts out “Pay and Chase”.

46.10.3 PHP, HMO, Triwest

Medi-Cal beneficiaries covered by PHP, HMO, Triwest, and other comprehensive health plans (for example, Kaiser, Secure Horizons) must use these services. Medi-Cal will reject bills for services provided to beneficiaries with OHC codes “F”, “K”, “C”, or “P”. Medi-Cal will only pay for services provided to beneficiaries enrolled in these plans when:

• The service is not a covered benefit under the designated plan (e.g., eye glasses, dental, prescriptions), or

• The service is determined to be a medical emergency and occurs outside of the plan’s geographic service area (e.g., persons having Kaiser must use their Kaiser coverage when within a 30-mile radius of any Kaiser facility).

Note:
For either of these situations, the beneficiary must obtain a payment denial letter from the health plan. The Medi-Cal provider must attach the denial letter to the claim when submitting a bill for Medi-Cal payment.
46.11 Cost Avoidance Coverage

46.11.1 Identification

Private health insurance coverage which must be coded with the cost avoidance OHC code may be identified by either DHCS or by the EW.

46.11.2 DHCS Responsibility

DHCS places the cost avoidance code directly on MEDS when a beneficiary is identified as having other health coverage.

DHCS obtains OHC information as a result of data processing tape matches between MEDS and certain private health insurance companies.

A County Eligibility Worker Alert (CEWA) will be generated by DHCS when a match takes place.

46.11.3 EW Responsibility

The EW must then update the OHC information in CalWIN for the identified person(s).

Only the primary subscriber (usually a parent) is identified on the match list.

Important:

If other family members also have the same full coverage, the EW must update their OHC in CalWIN with the appropriate information.

46.11.4 Recording OHC in CalWIN and MEDS

At intake and at redetermination, EWs must identify beneficiaries who have coverage under a private health insurance policy.

The EW must enter the appropriate OHC information in CalWIN any time a client reports other health coverage [Refer to “EW Actions,” page 46-4].
Other Health Coverage (OHC)

The EW must also view MEDS to ensure the correct OHC code is recorded.

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>OHC Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare HMO (e.g., Secure Horizons), Kaiser, Triwest</td>
<td>“F”, “K” or “C” (“F” always takes precedence).</td>
</tr>
<tr>
<td>Any other PHP/HMO</td>
<td>“P”</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>“D”</td>
</tr>
<tr>
<td>Dental Only policies</td>
<td>“L”</td>
</tr>
<tr>
<td>Any carrier (other than the above, includes multiple coverage)</td>
<td>“V” (cost avoidance)</td>
</tr>
</tbody>
</table>

Note:
Since DHCS cannot obtain reimbursement from private PHP and HMO such as Kaiser and Secure Horizons, the importance of the “F”, “K”, “C”, and “P” coding on the MEDS record cannot be overemphasized.

46.11.5 Effective Date of Cost Avoidance

Applicants - The first month of eligibility.

Recipients - The first of the future month.

46.12 OHC Information on Medi-Cal Records

46.12.1 OHC/HIAR SCREEN on MEDS

When there is private health insurance coverage, the following information will appear on the beneficiary’s Health Insurance System Action Request (HIAR) screen on MEDS. [Refer to User’s Guide to State Systems Handbook, “HIAR - Health Insurance Action Request,” page 1-72.]

- Name of carrier
- Policyholder name
- Policy number
- Policy start and stop dates
- Employer name and address
- Scope of coverage
• Whether dependent coverage is available.

Note:
The information may be useful in responding to beneficiaries' inquiries and in identifying insurance carriers. **The worker must ensure personal information found in MEDS pertaining to the absent parent is NOT disclosed.**

46.12.2 Providers

Providers will be required to bill the other insurance carrier before billing Medi-Cal for those services included in the scope of coverage. Claims for services not within the scope of coverage may be billed to Medi-Cal as though the beneficiary had no insurance available. There are Federal exemptions to cost avoidance (pre-natal and preventive pediatric services and cases involving IV-D child support enforcement).

46.12.3 Information Lacking

If the client has private health insurance, but the Medi-Cal program lacks information about the coverage, the word “COMPREHENSIVE” will appear on the record instead of the codes. This will alert providers to bill all services to the insurance company.

Clients will be notified to call their EW if the health insurance information on the Medi-Cal record is incorrect.

46.12.4 EW Responsibility

It is the EW's responsibility to update the MEDS OHC code when recipients, including SSI/SSP recipients, report that the OHC code on their Medi-Cal record is erroneous or that the insurance coverage has terminated or never existed. [Refer to “Verification,” page 46-26.]

The recipient's MEDS record must be updated for each month affected to ensure proper claims processing.
**Important:**

The Social Security office is responsible for collecting OHC information ONLY when making an initial SSI/SSP determination or redetermination. Any corrections of or updates to OHC information for SSI/SSP recipients must be completed by the EWs.

### 46.12.5 Verification

To insure that Medi-Cal is the payor of last resort for all Medi-Cal beneficiaries, including SSI/SSP eligible individuals, EWs must verify termination of OHC prior to removal of any OHC code from MEDS. Acceptable verification is either:

1. A payroll or pension check stub which shows deductions for private health insurance have ceased.

2. An Explanation of Benefits or termination letter from the insurance carrier showing the date the policy terminated.

**Note:**

If the letter indicates that continuation of medical benefits is available under COBRA, and the beneficiary has a high cost medical condition, refer the client to the DHCS Health Insurance Premium payment Unit at HIPP@dhcs.ca.gov.

3. An affidavit signed by the Medi-Cal beneficiary or their representative stating he/she no longer has, or never had OHC. The affidavit should include the date the policy terminated if known. This affidavit may be used when:

   - An erroneous OHC from a data match appears,
   - Client, custodial parent or guardian cannot verify termination,
   - A geographical barrier exists, or
   - A domestic violent situation exists.

For Supplemental Security Income/State Supplementary Payment (SSI/SSP) cases, where there is no county case record, the Eligibility Worker (EW) must view the documentation prior to removing the OHC code from MEDS.
46.12.6  Temporary OHC Removal

To remove OHC for immediate need cases, staff may use an EW 15 or EW 55 (for SSI/SSP cases) immediate need transaction to update the OHC Code for the current month to a value of “N.” Do not use other OHC values as this will display the incorrect OHC information to providers.

Do not use EW 15 or EW 55 transaction to change OHC carrier information (e.g. scope of coverage changes).

46.13 Removal of OHC Codes for Victims of Domestic Violence

When victims of domestic violence and abuse decide to leave the home, they (both adults and children) need protection from the abuser who often is enraged and may try 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.

46.13.1  Problem

The problem occurs in cases where the victims are Medi-Cal beneficiaries who have other health coverage (OHC) through the abuser. In most situations, the victims are in immediate need of medical care.

When a victim uses Medi-Cal to obtain services, the abuser’s OHC information will appear in MEDS and the OHC will be billed for the services provided. When this happens, an explanation of benefits (EOB) statement is sent to the holder of the OHC, in these cases, the abusers. The EOB normally indicates where the victims obtained services and, consequently, places the victims at risk for additional violence from the abuser who now knows their whereabouts.

46.13.2  EW Responsibility

It is critical that the OHC code be PERMANENTLY removed from MEDS to ensure the safety of the victims when the EW becomes aware that a Medi-Cal beneficiary is the victim of domestic violence.
Written verification to support the domestic violence claim is not necessary. However, the EW must DOCUMENT the reason for the OHC removal in the Maintain Case Comments window in CalWIN.

**Removing the OHC Code from MEDS**

To remove the OHC code from MEDS, complete the online form available on the California Department of Health Care Services (DHCS) website or call 1-800-541-5555 (press option 2 for beneficiary). The request MUST include the following information:

<table>
<thead>
<tr>
<th>Online Form Fields</th>
<th>What to Enter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal No.</td>
<td>CIN of the beneficiary</td>
</tr>
<tr>
<td>Last Name, First Name, Date of Birth</td>
<td>Name and DOB of the beneficiary</td>
</tr>
<tr>
<td>Remove all active Other Health Coverage</td>
<td>Yes</td>
</tr>
<tr>
<td>Carrier Code</td>
<td>If known, enter code; otherwise, leave blank.</td>
</tr>
<tr>
<td>Carrier Name</td>
<td>Name of the OHC carrier</td>
</tr>
<tr>
<td>Policy Stop Date</td>
<td>Date needed to terminate the OHC code</td>
</tr>
<tr>
<td>Comments</td>
<td>Reason why the OHC needs to be terminated (i.e. Good Cause- Domestic violence victim)</td>
</tr>
<tr>
<td>Submitter’s Name</td>
<td>Eligibility Worker’s Name</td>
</tr>
<tr>
<td>Phone Number</td>
<td>Eligibility Worker’s Phone Number</td>
</tr>
<tr>
<td>E-mail Address</td>
<td>Eligibility Worker’s e-mail address</td>
</tr>
</tbody>
</table>

**Note:**

When the OHC information is preventing immediate access to care and the client has signed an affidavit that he/she never had the OHC coverage, it may be necessary to have the client put on the “no carrier match list.” For these situations, also enter “no carrier match list” in the “Comments” field of the online form.

**Removing OHC Information from CalWIN**

The OHC information must also be removed (end dated) from the following CalWIN windows:

- **Collect Individual Attributes Detail** window, [Health Care Information] tab, and
46.14 OHC for Foster Care/Adoption Assistance Children

46.14.1 Problem

When a beneficiary has Other Health Coverage (OHC), whether through self-reporting or electronic health data exchange, the OHC data is recorded on MEDS.

The current process of posting OHC codes does not take into consideration access to care and inappropriate disclosure issues for children in Foster Care (FC) and Adoption Assistance Program (AAP).

46.14.2 OHC Coding Changes

In May 2010, the State made modifications behind the scenes to prevent the OHC code from being overlaid when OHC information is reported for a child receiving Medi-Cal benefits under a FC or AAP Aid Code.

The new logic will automatically change the OHC code to “N” on MEDS to indicate no coverage and enter “Y” as the OHC-SOURCE. The reported OHC code will be posted in the ORIGINAL-OHC code fields on the [INQC] screen until the child becomes ineligible for Medi-Cal benefits under either the FC or AAP program.

46.14.3 SSI Children

MEDS changes are being planned for FC/AAP children who are on SSI. Until the changes are installed, staff must request the Third Party Liability Branch-OHC Unit to modify the OHC for these children.
46.14.4 Recording OHC in CalWIN

The OHC information reported by the FC/AAP child must be entered in CalWIN on the **Collect Individual Attributes Detail** and **Collect Health Care Coverage Detail** windows to ensure the OHC data is interfaced to MEDS ORIGINAL-OHC fields.

This is necessary so that when the child leaves FC/AAP and transitions into a regular Medi-Cal program, MEDS would already have the OHC data and can update the code to reflect the appropriate OHC without delay.

46.15 Repayment for Medical Services

46.15.1 Rule

Beneficiaries shall be advised that if they receive insurance payments from their private coverage for a service which has been paid by Medi-Cal, they must repay Medi-Cal.

46.15.2 Endorse Checks

Beneficiaries should endorse checks from insurance carriers as follows:

- Name of Payee—Party to whom the check is made payable. Signed either by the payee or their agent.

- Medi-Cal Identification Number of Beneficiary—This may be a different person than the one who received the check.

- “For Deposit Only to Health Care Deposit Fund”—This will ensure that the check will be properly applied to the state fund only.

- Beneficiaries must provide the date(s) of service, the provider’s name, and a daytime phone number where they can be reached.
46.15.3 Provider Overpayments (OP) Program

Any health insurance payments received by beneficiaries for services covered by Medi-Cal must be reported and repaid to:

Department of Health Care Services
Third Party Liability & Recovery Division
Overpayments Section - MS 4720
P.O. Box 25
Sacramento, CA 95889-7425

46.15.4 DHCS Recovery

DHCS will recover payments made for Medi-Cal services that should be paid by the client's OHC.

DHCS distributes OHC payments collected which exceed both the Medi-Cal payments for the service and the administrative costs in collecting the payment as follows:

• The difference between the provider's billing and the amount paid by Medi-Cal shall be paid to the provider, subject to the amount of the excess available.

• Funds remaining shall be paid to the legally entitled person or entity.