

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

Requirements for Third Party Liability -
Payment of Claims

1) The requirement in 433.139(b)(3)(ii)(C) is met, as follows:

Medical providers use a third party resource (TPR) explanation code on the claim to communicate that the service involves insurance through the absent parent in a IV-D enforcement case, and that 30 days have lapsed since the date of service, and that the provider has not received payment from the third party resource. The MMIS system will edit for the 30 day requirement. If less than 30 days have lapsed, the claim will be rejected.

On a quarterly basis, the MMIS system produces a listing of all claims processed for recipients with third party resource coverage. This report includes all claims with a TPR explanation code. This report is used by the Utilization Review group to identify any fraudulent or erroneous billings through verification with the third party carriers.

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Supersedes
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2) The requirement in 433.139(f)(2) is met, as follows:

Threshold amounts. With the implementation of the Post Payment Recovery System the threshold amount for the post payment recovery of claims are:

- A) For claims involving Medicare, zero.
- B) For claims involving private health insurance, zero.
- C) For drug claims, \$25.
- D) For ICF/MR and IMD, zero.
- E) For claims paid under the provisions of 433.139(b)(3), zero.

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3) The requirement in 433.139(f)(3) is met, as follows:

- A) Oregon accumulates drug claims to \$25 before billing. If the accumulated total is less than \$25 for the 60 ~~day~~ period prior to the billing generation, the claims will be added to the next billing cycle (every 60 days for drug claims). For all other claim types, Oregon does not accumulate billings by dollar amount or period of time and the weekly Post Payment Recovery System billing cycle is run immediately following the weekly MMIS claims cycle. All recoveries are sought within the time limits specified in 433.139(d).

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THIRD PARTY LIABILITY: Payment of Health Insurance Premiums

In accord with Section 1903(a)(1) of the Act, Oregon will on a case-by-case basis pay health insurance premiums to establish or maintain coverage for Medical Assistance recipients when it is determined to be cost beneficial. Examples are:

1. When the recipient was recently separated from employment due to a layoff, medical condition or pregnancy, and retains the option to continue with the existing health coverage through the former employer.
2. When the recipient is a dependent of an employed parent or other liable party, with option to purchase such coverage.

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SUBJECTS	POSTAL DATE 1/2/88
TN#	DATE TO GO
COMMENTS	

Third Party Liability: Payment of Group Health Plan Premiums

In accord with Section 1906 of the Act, implementing Section 4402 of OBRA of 1990, Oregon requires mandatory enrollment of Medicaid recipients in cost effective group health plans as a condition of Medicaid eligibility, except for an individual who is unable to enroll on his/her own behalf. Oregon pays the group health insurance premium for Medicaid individuals if cost effective. Oregon may also pay the premium for non-Medicaid individuals if cost effective and if it is necessary in order to enroll the Medicaid recipient in the group health plan. Oregon pays, subject to state payment rates, deductibles, coinsurance and other cost sharing obligations under the group health plan for Medicaid recipients enrolled in the group health plan for items and services covered under the State Plan. Oregon pays for items and services provided to Medicaid recipients under the State Plan that are not covered in the group health plan. The group health plan will be treated as a third party resource as described in the State Plan for 42 CFR 433.138 and 433.139.

The following guidelines are used to determine cost effectiveness.

1. Determine if the group health plan is a basic/major medical policy or a health maintenance organization (HMO).
2. Determine the premium amount to be paid, converting any premiums that are not monthly, to a monthly amount.
3. Determine the number of Medicaid individuals to be covered.
4. Determine the average premium cost per Medicaid individual.
5. Determine the average monthly Medicaid cost savings for Medicaid persons who will be covered by the basic/major medical coverage or HMO coverage using the Medicaid Savings Chart.

The Medicaid Savings Chart is updated yearly. It is based on the MMIS WMMS757R-A report, which is an analysis of the costs for Medicaid recipients with third party resources versus those Medicaid recipients without third party resources. The Medicaid Savings Chart is divided into categories of assistance, as follows:

- a. Old Age Assistance
 - b. Aid to Dependent Children
 - c. Aid to the Blind
 - d. Aid to the Disabled
 - e. Foster Care
6. The Medicaid agency will pay the premium amount if the premium cost per Medicaid individual is equal to or less than the corresponding amount shown on the Medicaid Savings Chart.

The cost effectiveness of the premium payment will be reevaluated at each redetermination.

9/14

8/30/91

12/1/91