2230 – THIRD PARTY RESOURCES

POLICY STATEMENT	Applicants for and recipients of Medicaid are required to provide information regarding third party resources (TPRs) available to AU members and must assign their rights to these TPRs to the Division of Medical Assistance (DMA).

BASIC CONSIDERATIONS

TPRs are medical benefits and include but are not limited to the following:

- CHAMPUS (active duty insurance)
- CHAMPVA (disabled veteran insurance)
- Court ordered payments of medical costs by an absent parent (AP)
- Court awards or trusts which provide for payment of medical expenses
- Health insurance policies (including the AP's)
  - private
  - indemnity
  - group
  - liability
- Medicare
- Worker's Compensation
- Special Needs Trusts or any trust or legal document that specifies monies are due to the State (this would include lawsuit settlements, workman's compensation settlements, etc.)

Recipients of Newborn Medicaid are not required to provide information regarding TPRs.

Payments from TPRs are assigned to DMA when the A/R signs the application form for Medicaid.

Form DMA-285, Health Insurance Information Questionnaire, transmits information about TPRs to DMA, along with a release of information statement and a statement of assignment of payments.

The Health Insurance Premium Purchase (HIPP) Referral Form transmits information to DMA for potential purchase of an A/R's health insurance. DMA will make the cost effective determination.

BASIC CONSIDERATIONS (cont.)

The Employer Statement of Available Insurance is a DMA form to accompany the HIPP referral when insurance is available for the A/R through an employer.

A/R must also provide information regarding a TPR held by an absent parent unless good cause is asserted and upheld. Good cause for refusing to cooperate is based on good cause standards for non-cooperation with the Office of Child Support Recovery

Applicants who refuse to cooperate in the TPR process without good cause or who refuse to enroll or who disenroll from health insurance which has been determined by DMA to be cost effective to purchase under the HIPP program are ineligible for

PROCEDURES

Use the following charts to determine what action to take in reviewing the TPR requirement at application, reviews and when a change in TPR occurs.

chart 2230.1 – tpr	
If TPR is reviewed	**THEN**
at application AND the A/R has a TPR	complete Form DMA-285 for each TPR available to the A/R and submit the original form(s) to DMA, along with copies of any available documents verifying the TPR AND complete a DMA HIPP Referral Form and forward the original to DMA if the A/R has health insurance available OR complete Form 138 to document waiver of the TPR requirement because of Good Cause for non-cooperation with CSE or document as to why a HIPP referral was not made. **NOTE**: Do not submit Form DMA-285 to DMA if Medicare is the only TPR. **NOTE**: Do not make a HIPP referral under the following circumstances: • the only insurance is a Medicare Supplemental policy • the A/R will not be Medicaid eligible on an ongoing basis • the A/R is eligible for QMB, SLMB, QI-1 or QI-2 only.

at application AND there is no TPR available to the A/R	document appropriately. Form 285 is **not** required. OR complete Form 138 to document waiver of the TPR requirement because of Good Cause for non-compliance.
at a review	discuss TPR with the recipient. Document the system appropriately if there is no change.
when there is a change in TPR	complete a new Form DMA-285 to record any changes in an existing TPR or to report any new TPRs AND submit Form DMA-285 and/or HIPP Referral Form to DMA with the updated and/or new TPR information.
When a TPR has been canceled	submit a copy of the original Form DMA-285 and/or HIPP Referral Form to DMA with **CANCELED** written on the top in bold red letters. Include the date of cancellation, if available.
When a SSI recipient needs to assign TPR	follow the procedures used at application. Write **SSA Compliance** in red in the top right corner of the Form DMA-285 and submit it to DMA, even if Medicare is the only TPR.
When the TPR pays DMA more than the amount DMA paid for the service	DMA will issue a refund to the client and notify the county via the state office of the refund. Refer to Chapter 2400, Income for treatment of refunds from DMA.

PROCDURES
(cont.)

Trusts and Other Legal Documents	Any trust, such as a Special Needs Trust, or other similar legal document which contains a clause that provides for repayment of money to the state for medical treatment on behalf of an A/R is considered a TPR and is to be reported to DMA. Annotate Form 285 to indicate there is a trust document. Attach a copy of the trust or legal document and mail to DMA.

Form 285, Health Insurance Information Questionnaire, should be mailed to:

Public Consulting Group
5660 New Northside Drive
Suite 750
Atlanta, Georgia 30328

HIPP Referral Form should be mailed to:

DCH/HIPP Unit
P.O. 1500
Atlanta, Georgia 30301

SPECIAL CONSIDERATIONS

Payment From an Insurance Policy Based on Disability

If the A/R receives payments based on disability from an insurance policy, treat the payments as follows:

If the payments are designated by the policy owner to cover medical expenses only, consider the payments to be a TPR. Report the payments to DMA on Form DMA-285.

If the payments are designated to cover lost wages or to be used at the discretion of the policyholder (A/R), consider the payments to be unearned income if the payments cannot be assigned.

SPECIAL CONSIDERATIONS (cont.)

Do **not** make HIPP referrals on A/Rs:

- with no insurance or no access to insurance
- whose only insurance is a Medicare Supplement, indemnity* cancer policy
- whose only insurance is through an HMO
- who are only eligible for QMB, SLMB, QI-1 or QI-2
- who do not have ongoing Medicaid coverage (no three mor prior only)
- whose coverage is through an absent parent
- who are refugees
- when an employee pays 100% of the policy cost
- where no employer information is available (if applicable)
- when the name of the policy holder is not known
- when there is no known person to contact for referral

If an A/R has multiple health insurance policies, refer only the primary policy to HIPP.

*For example, an individual policy that reimburses a policyholder a set dollar amount for each day the policy holder is inpatient in an acute care facility should not be referred to the HIPP program.

A HIPP referral is not necessary for AMN A/Rs if spenddown is met at or near the end of a budget period. Refer AMN A/Rs when they will be defacto eligible for multiple budget periods.