Georgia Department of Medical Assistance
Cost Effective Determination
Alternative Guidelines
Attachment to Att. 4.22-C

I. The State of Georgia uses the following methods to determine the cost effectiveness of paying group health insurance premiums for Medicaid recipients:

1. Cost Effectiveness Based on Expenditure Projection

The determination of cost effectiveness is based on the comparison of the amount of the annual premium, deductibles, coinsurance, policyholder cost sharing obligations, and additional administrative costs against the average annual cost of Medicaid expenditures for the recipient's eligibility aid category on a statewide basis. It is used as an initial screening step for all Medicaid recipients who have group health insurance benefits to determine whether it is cost effective to purchase. The Medicaid Management Information System (MMIS) is utilized to obtain the average annual Medicaid costs statewide by aid category. A client's case is determined as cost effective if the amount of the premium, deductibles, coinsurance, cost sharing obligation, and administrative costs are less than the Medicaid expenditures for an equivalent set of services.

2. Cost Effectiveness Based on Client Diagnosis

The determination of cost effectiveness is based on the comparison of premium amounts and policyholder obligations against the actual claims experience of the recipient. Documentation of actual expenditures consists of Explanation of Benefits (EOB's) from the recipient's health carrier for previous charges relating to a specific diagnosis or Medicaid expenditures for previous periods of the client's eligibility. This method is used when the method described in #1 above does not prove to be cost effective. Such diagnoses would include cancer, chronic heart disease, congenital heart disease, end stage renal disease and AIDS. This list will be expanded as diagnoses associated with long term care are identified. This method of cost effective determination is also appropriate for short term high expense treatments. A client's case is considered as cost effective when actual claim expenditures associated with the diagnosis exceed the premium amounts and policyholder obligations.

TRANSMITTAL 94-009
APPROVED 10-6-94
EFFECTIVE 7-1-94
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II. Because Federal Financial Participation (FFP) is available for the payment of premiums for Medicaid recipients enrolled in a cost effective group health plan:

1. Medicaid will pay the health insurance premiums for Medicaid recipients with policies likely to be cost effective to the Medicaid program. Payments shall be made directly to the insurer providing the coverage, the employer or to the Medicaid recipient or guardian.

2. Medicaid will pay the Medicaid allowable amount for all items and services provided the Medicaid recipient under the State Plan that are not covered under the group health plan.

3. Medicaid will provide for the payment of premiums when cost effective for non-eligible family members to enroll a Medicaid eligible family member in the group health plan.

4. Medicaid will treat the group health plan as a third party resource in accordance with Georgia Medicaid TPL cost avoidance policies.

5. The health carrier, employer, recipient or non-Medicaid eligible family member will immediately notify this agency of any event that might affect the policyholder status of the cost effectiveness of the Health Insurance policy.

6. Medicaid will receive referrals for potential candidates for the payment of premiums. Referral systems have been established through high cost hospital providers, AID Atlanta and the local Department of Family and Children Services.

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EFFECTIVE 7-1-94
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