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5101:3-2-25 ~~Third-party liability~~Coordination of benefits: hospital services.

(A) All hospitals are to utilize third-party resources for all services a consumer receives while in the hospital. If a hospital receives reimbursement from a third-party subsequent to submitting a claim or subsequent to receiving payment from the department, the hospital is to repay the department by submitting a claim adjustment. Patient liabilities associated with persons eligible for medicaid under spend-down provisions are considered a third-party resource. Benefits available through Title XVIII of the Social Security Act under medicare, part A and part B, or through medicare part C (medicare advantage), are considered third-party resources, including medicare part A lifetime reserve days.

(B) The following payment provisions apply when billing for services provided to medicaid eligibles having available resources.

(1) For Qualified Medicare Beneficiaries (QMB), QMB Plus, Specified Low-Income Beneficiaries Plus (SLMB Plus), and Full Benefit Dual Eligibles (FBDE), the following payment provisions apply to cost-sharing liability for inpatient services.

(a) For purposes of paragraph (B)(1) of this rule, the "medicaid maximum allowed amount" is the amount that would be payable by medicaid if the hospitalization were billed, in its entirety, to the department as a medicaid-only claim for a medicaid eligible consumer. The medicaid maximum allowed amount is calculated as:

(i) Described in rule 5101-3-2-07.11 of Attachment 4.19-A in the case that a hospital is paid in accordance with the ~~diagnostic~~diagnosis related grouping (DRG) prospective payment system; or

(ii) Described in rule 5101-3-2-22 of Attachment 4.19-A in the case that a hospital is paid on a reasonable cost basis.

(b) Except as described in paragraph ~~(C)~~(B)(3) of this rule, for persons described in paragraph (B)(1) of this rule, the department will pay as cost sharing for inpatient hospital services the lesser of:

(i) The sum of the deductible, coinsurance and co-payment amount as provided by medicare part A; or

(ii) The medicaid maximum allowed amount, as described in paragraph (B)(1)(a) of this rule, minus the total prior payment, not to equal less than zero. The total prior payment includes the amount paid or payable by medicare and any other applicable third party payment for services billed.

(c) If the department has a cost-sharing liability but is unable to calculate a medicaid maximum as described in paragraph (B)(1)(a) of this rule, the department shall pay the sum of the deductible, coinsurance and co-payment amount as provided by medicare part A.

(d) If a patient who is jointly eligible for medicare part A and medicaid exhausts medicare part A benefits while hospitalized, and the patient's hospitalization exceeds the applicable medicare threshold, the department will pay the difference between that amount payable by medicare and the medicaid maximum allowed amount as described in paragraph (B)(1)(a) of this rule.

~~(2) When a consumer is entitled to medicare part B benefits, the department pays the amount of the medicare~~

~~deductible and coinsurance minus any other resources available to the recipient for hospital services including health insurance benefits.~~

(2) For Qualified Medicare Beneficiaries (QMB), QMB Plus, Specified Low-Income Beneficiaries Plus (SLMB Plus), and Full Benefit Dual Eligibles (FBDE), the following payment provisions apply to cost-sharing liability for hospital services covered by medicare part B:

(a) For purposes of paragraph (B)(2) of this rule, the "medicaid maximum allowed amount" is the amount that would be payable by medicaid if the hospitalization were billed, in its entirety, to the department as a medicaid-only claim for a medicaid eligible consumer. The medicaid maximum allowed amount is calculated as:

(i) Described in rule 5101-3-2-07.11 of Attachment 4.19-A in the case that a hospital is paid in accordance with the diagnosis related grouping (DRG) prospective payment system; or

(ii) Described in rule 5101-3-2-22 of Attachment 4.19-A in the case that a hospital is paid on a reasonable cost basis.

(b) Except as described in paragraph (B)(3) of this rule, for persons described in paragraph (B)(2) of this rule, the department will pay as cost sharing for hospital services covered by medicare part B the lesser of:

(i) The sum of the deductible, coinsurance and co-payment amount as provided by medicare part B; or

(ii) The medicaid maximum allowed amount, as described in paragraph (B)(2)(a) of this rule, minus the total prior payment, not to equal less than zero. The total prior payment includes the amount paid or payable by medicare and any other applicable third party payment for services billed.

(c) If the department has a cost-sharing liability but is unable to calculate a medicaid maximum as described in paragraph (B)(2)(a) of this rule, the department shall pay the sum of the deductible, coinsurance and co-payment amount as provided by medicare part B.

(3) For Qualified Medicare Beneficiaries (QMB), QMB Plus, Specified Low-Income Beneficiaries Plus (SLMB Plus), and Full Benefit Dual Eligibles (FBDE) enrolled in medicare part C managed health care plans (medicare advantage plans) the department pays in accordance with Supplement 1 to Attachment 4.19-B.

(4) For inpatient hospital services, if a consumer is entitled to hospital insurance benefits other than medicare including health insurance benefits, the department pays either the applicable DRG prospective payment as described in rule 5101-3-2-07.11 of Attachment 4.19-Aor the payment applicable for services reimbursed on a reasonable cost basis as described in rule 5101:3-2-22 of Attachment 4.19-A, minus any resources available to the patient for hospital services including health insurance benefits. Such resources may include medicare part B payments including health insurance benefits and patient liabilities associated with persons eligible on a spend-down basis as described in paragraph (A) of this rule. Such resources may include patient liabilities associated with persons eligible on a spend-down basis as described in paragraph (A) of this rule. For inpatient, if the resources available to a recipient

equal or exceed amounts payable in accordance with this paragraph, the department makes no payment for the hospital services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OHIO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18-A of this state plan), if applicable, the Medicaid agency uses the following general method of payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments designated with the letter "SP" on page 2.

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page __ in item __ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments designated with the letters "MR" on page 2.

3. Payments are up to the amount of a special rate, or according to a special method, described on Pages 3 and 3a under items 1, 2 and 3 of this Supplement, for those groups and payments designated with letters "NR" on page 2.

4. Any exceptions to the general methods used for a particular group or payment are specified on Page __ in item __ of this attachment (see 3 above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OHIO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A MR/NR deductibles	MR/NR coinsurance
	Part B MR/NR deductibles	MR/NR coinsurance
Other Medicaid Recipients	Part A MR/NR deductibles	MR/NR coinsurance
	Part B MR/NR deductibles	MR/NR coinsurance
Dual Eligible (QMB Plus)	Part A MR/NR deductibles	MR/NR coinsurance
	Part B MR/NR deductibles	MR/NR coinsurance

3. Cost sharing for outpatient hospital services provided as a Medicare Part B benefit are reimbursed at the lesser of:

   a. The sum of the deductible, co-payment and coinsurance amount as provided by Medicare Part B or;

   b. The Medicaid maximum allowed amount minus the total prior payment. The total prior payment includes the amount paid by Medicare and any other applicable third party payments. The Medicaid maximum allowed amount is the amount that would be payable by Medicaid if the outpatient services were billed, in its entirety, to the department as a Medicaid-only claim.

OS Notification

State/Title/Plan Number: Ohio 12-002

Type of Action: SPA Approval

Required Date for State Notification: June 10, 2012

Fiscal Impact: FY 2012 $(19,402,000)
FY 2013 $(25,869,000)

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective for services on or after January 1, 2012, this amendment revises reimbursement methodology, for qualified Medicare beneficiaries (QMB) including QMB Plus and Medicaid consumers enrolled in Medicare Part B, applicable to cost-sharing liability for hospital services covered by Medicare Part B. Funding the non-Federal share of these payments comes from State appropriations. The State met public process requirements. There are no issues with the UPL. There are no concerns with regards to access to care and services, the service which the state agrees to pay at the Medicaid rate for a dual eligible would be a non-covered Medicaid service. This SPA has been cleared by the NIPT, as well as by Cathy Sturgill and Nancy Dieter in CO.

The State will pay the lesser of the sum of deductible, coinsurance and co-payment amount as provided by Medicare Part B, or the Medicaid maximum allowed amount which is described in the State plan.

Other Considerations: This plan amendment drew interest from Senator Sherrod Brown from Ohio. The senator's office is hearing from Ohio constituents about the status and expected approval.

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

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National Institutional Reimbursement Team