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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 21-0034

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Summary Page
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

January 24, 2022

Maureen M. Corcoran, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

Re: Ohio State Plan Amendment (SPA) Transmittal Number 21-0034

Dear Ms. Corcoran:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number 21-0034. This amendment clarifies that a providers must wait 100 days after billing a non-responsive child enforcement-related third party in order to be eligible for Medicaid reimbursement.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations at 42 CFR 433.139. This letter is to inform you that Ohio Medicaid SPA 21-0034 was approved on January 24, 2022, with an effective date of December 1, 2021.

If you have any questions, please contact Christine Davidson at (312) 886-3642 or via email at christine.davidson@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

cc: Rebecca Jackson, ODM
Gregory Niehoff, ODM
Andrea Ormiston, CMCS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES**	1. TRANSMITTAL NUMBER: **21-034 Revised**	2. STATE **OHIO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **December 01, 2021**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 433.139	7. FEDERAL BUDGET IMPACT: a. FFY 2022 $ 0 b. FFY 2023 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.22-B Pages 1-2	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.22-B Pages 1-2 (TN 21-013)

10. SUBJECT OF AMENDMENT: Clarifying that providers must wait 100 days after billing a non-responsive child support enforcement-related third party to be eligible for Medicaid reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
13. TYPED NAME: **MAUREEN M. CORCORAN**	
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: December 1, 2021	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 1, 2021	18. DATE APPROVED: **01/24/2022**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: December 1, 2021	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: James G. Scott	22. TITLE: Director, Division of Program Operations

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

Requirements for Third Party Liability – Payment of Claims

ODM's TPL program is designed to function primarily as a cost avoidance system. This method was chosen as the most efficient and cost effective option. Claims for medical services, unless excluded by federal law, are cost-avoided when a third party liability policy exists within ODM's claims payment system. Claims paid prior to the third party coverage being entered into the claims system are pursued by a vendor for post-payment recovery as described in this attachment.

1. Monitoring provider compliance (42 CFR 433.139(b)(3)(ii)(C)):

   The State Plan as referenced herein requires providers to bill third parties. When the probable liability of a third party is established, ODM notifies the provider that the claim was cost avoided due to the existence of TPL. Cost avoided services are identified with an Explanation of Benefits Code which provides the third party payor information that is transmitted to the provider with non-payment remittance advice. ODM further certifies that our claim payment system enforces cost avoidance for prenatal services. The only exceptions to the cost avoidance requirements are as follows:

   a. Under the exemption authority found in 42 CFR 433.139(b) and 42 CFR 433.147(c), children that have been legally placed in the custody of an Ohio county Public Children's Services Agency (PCSA) or related entities are excluded from TPL cooperation and are exempt from post-payment recovery unless it is confirmed that the child will not be put at risk for doing so (e.g. medical support order).

   b. Under exemption authority found in 42 CFR 433.139(b)(3)(i), ODM makes payments without regard to potential third party liability for preventive pediatric services, including early and periodic screening, diagnosis and treatment services (EPSDT), except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date of service.

   Providers are monitored for compliance with insurance billing requirements through a post payment recovery process by a vendor. The vendor is responsible for identifying claims with potential third party liability where Medicaid has paid primary. The vendor will either directly bill the primary insurance or involve the provider to recoup the amount Medicaid has paid.

   If a provider has billed a third party and has not received payment, the provider will be required to submit proof that they have attempted to bill the third party three times within a 90-day period and not received payment. The provider must have waited 90 days from the date of service and not received payment from the third party before the state will pay.

   If the claim is related to medical support enforcement, providers must submit proof they billed the third party three times within a 100-day period and not received payment. The provider must have waited 100 days from the date of service and not received payment from the third party before the state will pay, except that the State may make such payment within 30 days after such date if the State determines so is cost-effective and necessary to ensure access to care.

   When a Medicaid-enrolled behavioral health agency certified by the Ohio Department of Mental Health and Addiction Services has billed a third party, but the third party has not paid the claim within 30 days, and the provider has verified concerns regarding recipients' access to care, the provider may submit the claim to Medicaid and must include a certification statement that the

provider waited 30 days and no response was received from the third party. These claims will be pursued for post-payment recovery by a vendor as described in this attachment until the institution of new contracts subsequent to managed care re-procurement.

2. Guidelines Used to Determine When to Seek Reimbursement from a Liable Third Party (42 CFR 433.139(f)(2)):

   a. Health Insurance

   For medical claims that were paid by ODM prior to the TPL policy being entered into the eligibility system or claims system, recovery is pursued by a vendor from the provider for amounts greater than $25 within three years of the claim from date of service. The timeframe is only one year from date of service if the provider would need to bill Medicare.

   For medical claims that were paid by ODM prior to the TPL policy being entered into the eligibility system or claims system, recovery is pursued by a vendor from the liable third party payer for amounts greater than $0.01 within a timeframe of six years of the claim from date of service.

   b. Casualty Recovery

   ODM uses a $250 threshold in determining whether to pursue casualty recovery after a liable third party payer has been identified. Personal injury investigative action occurs when hospital bills with trauma diagnoses having billed amounts equal to or greater than $250 that are accumulated over a one year timeframe from date of service. Audits of past claim recoveries have shown when a tort case totals less than $250 and no response has been received from recipient, it is not cost effective to pursue these cases after sending one letter unless recipient or attorney makes contact to the State Medicaid Agency.

3. Dollar amount or timeframe for seeking recovery (42 CFR 433.139(f)(3)):

   Health insurance recovery action on claim types likely to be covered by insurance occurs when payments made by the ODM are greater than $0.01.

   Personal injury investigative action occurs when hospital bills with trauma diagnoses having billed amounts equal to or greater than $250 that are accumulated over a one year timeframe from date of service. Investigative resources which would be required to pursue smaller bills can be used more productively to carry out tasks that yield much higher rates of return.