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

Medicaid and CHIP Operations Group

March 11, 2022

Lynnette R. Rhodes, Esq.
Executive Director, Medical Assistance Plans
Department of Community Health
2 Peachtree St., 36th Floor
Atlanta, Georgia 30303

Re: GA State Plan Amendment (SPA) 21-0013

Dear Executive Director Rhodes:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 21-0013. This amendment proposes to cost avoid for all prenatal, labor and delivery, and postpartum services.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations of the Bipartisan Budget Act of 2018 (BBA), the Medicaid Services Investment & Accountability Act of 2019 and 42 CFR § 447.201. This letter is to inform you that GA 21-0013 was approved on March 09, 2022 with an effective date of October 1, 2021.

If you have any questions, please contact Etta Hawkins at (404) 562-7429 or via email at Etta.Hawkins@cms.hhs.gov.

Sincerely,

James G. Scott, Director
Division of Program Operations

cc: Brian Dowd

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIA

Requirements for Third Party Liability
Payment of Claims

The State uses a coordination of benefits cost avoidance method of claims processing when third party liability is identified at the time a claim is filed. A coverage specific matrix is utilized to cost avoid claim payment for categories of service covered by third party resources. Claims are rejected and returned to the provider if the service being billed is most likely covered by a legally responsible third party as defined in 42 C.F.R. 433.136. If, after the provider bills the legally responsible third party and a balance remains or the claim is denied payment for a substantive reason, the provider can submit a claim to the State Medicaid Agency for payment of the balance, up to the maximum Medicaid payment amount established for the service. There are no thresholds used to trigger the cost avoidance process.

With certain exceptions, cost avoidance procedures will be applied to all services and claims, including claims for prenatal services, labor and delivery, and postpartum care services. Cost avoidance procedures will not be applied to claims for preventive pediatric care (including EPSDT), and the state will make payments without regard to potential third-party liability for pediatric preventive services, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.

Additionally, cost avoidance procedures will not be applied to claims covered by absent parent-maintained insurance under Part D of Title IV of the Act. The state shall make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 100 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.
The State seeks reimbursement from insurance carriers through a monthly system generated post-payment billing process when the existence of third-party liability is not known at the time of billing. A threshold of $100.00 per member or what is deemed cost effective by the Department must be met prior to seeking reimbursement from Health insurance resources.

The State seeks reimbursement from verified liable third parties on claim payments involving accidental injuries when total potential recovery is $250.00 or greater. Liens are filed if the recovery amount involves $500.00 or more in Medicaid expenditures. No threshold is applied to the identification of paid claims with trauma diagnoses.