

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

September 9, 2025

Stuart Portman, Executive Director
Medical Assistance Plans
Georgia Department of Community Health
2 Martin Luther King Jr. Drive SE
East Tower, 19th Floor
Atlanta, GA 30334

Re: Georgia State Plan Amendment (SPA) 25-0009

Dear Executive Director Portman:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0009. This SPA updates Georgia's Medicaid State Plan to reflect federal requirements for Third-Party Liability, ensuring compliance with the Consolidated Appropriations Act of 2022.

We conducted our review of your submittal according to statutory requirements in section 1902(a)(25)(I) of the Social Security Act. This informs you that Georgia's Medicaid SPA TN 25-0009 was approved on September 9, 2025, effective July 1, 2025.

Enclosed are copies of the approved Form CMS-179 and the approved SPA pages to be incorporated into the Georgia State Plan.

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

Sincerely,

Shantrina Roberts, Acting Director
Division of Program Operations

Enclosures

cc: Lynette Rhodes
Brian Dowd
Rebecca Dugger
Maxine Elliott
Melonie Wilson
Perri Smith

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: GEORGIARequirements 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. The State may recover its Medicaid payments from the portion of the beneficiary's settlement, judgement, or award designated for past or future medical expenses. No threshold is applied to the identification of paid claims with trauma diagnoses.

TN No. 25-0009

Supersedes

TN No. 21-0013Approval Date 09/09/25Effective Date 07/01/25

- Recovery of Medical Assistance All entities must accept the State's payment for a healthcare item or service on behalf of a recipient of medical assistance as the third-party payer's authorization of the provision of those services and shall not refuse to pay for a healthcare item or service solely on the basis that the third-party payer did not previously authorize such item or service. All entities must respond to the State inquiry regarding the status of a claim for payment for any healthcare item or service within 60 days of receiving the inquiry.

These provisions comply with section 202 of the Consolidated Appropriations Act, 2022.

TN No. 25-0009

Supersedes

TN No. NEW

Approval Date 09/09/25

Effective Date 07/01/25