Ohio
Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-16-04

TO: **Eligible Providers of Medicaid Services**
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: **John B. McCarthy, Director**

SUBJECT: **Changes to the Payment Methodology for Medicare Part B Cost Sharing**

Summary

As a result of the fiscal year 2016/17 state budget (Am. Sub. HB 64), the Ohio Department of Medicaid (ODM) eliminated individual provider exemptions when calculating prices for Medicare Part B crossover claims.

The changes went into effect for dates of service on or after January 1, 2016.

Rule 5160-1-05.3, Payment for Medicare Part B cost sharing which provides the payment methodology for Medicare Part B crossover claims, has been amended as Ohio exercised its authority under federal law (§1902(n)(2) of the Social Security Act) to not pay more than the Medicaid primary payer amount for Medicare Part B crossover claims. Prior to January 1, 2016, individual providers, including physicians, dentists, optometrists, podiatrists, chiropractors, nurse practitioners and certified-registered nurse anesthetists (CRNAs), were exempt from this payment methodology. As a result of the amended rule, they will now be subject to the new methodology. This change was necessary because it contributed to building the Department's appropriations established in Am. Sub. H.B. 64 of the 131st General Assembly. Hospitals, nursing facilities, and most other providers of Medicare Part B services, other than physician services, have been subject to this payment methodology since at least January 1, 2014. ODM also uses a similar payment methodology for Medicare Part A and C crossover claims. At this time, Ambulatory Surgery Centers (ASC) and End Stage Renal Disease (ESRD) provider types will continue to be exempt from the Medicare Part B crossover claims payment methodology.

Effectively, ODM pays the lesser of either the cost sharing that, absent Medicaid eligibility, would have been owed by the Medicare beneficiary or the difference between what Medicare paid and the Medicaid maximum allowable for the same service rendered, procedure performed, or item supplied. If the sum of the amounts paid by Medicare and all other third party insurers

exceeds the Medicare or Medicaid approved amount, then ODM will not make any additional payment to the provider, or will make a payment of zero dollars, and the service(s) are considered to be paid in full to the provider. See the examples below for further illustration of the new payment method.

Example 1: Jane is a beneficiary enrolled in Medicare Part B with $100.00 remaining towards the deductible. The service rendered on the crossover claim equals $150.00 however the Medicare allowable payment for the service rendered is $100.00. Medicaid's maximum allowable rate for the service rendered is $75.00. See below for examples of the payment calculation for each party on this claim using the new payment method.

1. Beneficiary still has to meet her deductible, therefore Medicare pays $0.00.
2. ODM maximum allowable for this service is $75.00.
3. Difference between Medicare paid and ODM maximum allowable rate is $75.00, ($75-$0).

Before the policy change, ODM would have paid the full Medicare allowable. Using the new payment method, ODM pays the lesser of either the cost sharing that would have been owed by the Medicare beneficiary or the difference between what Medicare paid and the ODM maximum allowable.

Before policy change	After policy change
Medicare pays $0.00	Medicare pays $0.00
ODM pays $100.00	ODM pays $75.00

Example 2: John is a beneficiary enrolled in Medicare Part B. The service rendered on the crossover claim equals $150.00 however the Medicare allowable payment for the service rendered is $100.00. Medicare paid $80.00 on the claim and the ODM maximum allowable rate for the service rendered is $75.00. See below for examples of the payment calculation for each party on this claim using the new payment method.

1. Medicare paid $80.00 with a remaining $20.00 in coinsurance, ($100-$80).
2. ODM maximum allowable rate is $75.00

Before the policy change, ODM would have paid $20.00. See below for examples of the calculated sum of the amounts paid by Medicare and all other third party insurers, using the new payment method. The sum exceeds the ODM maximum allowable amount, therefore ODM will not make any additional payment to the provider, or will make a payment of zero dollars, and the service(s) are considered to be paid in full to the provider. Providers are prohibited by OAC 5160-1-13.1 from balance-billing Medicaid beneficiaries.

Before policy change	After policy change

Medicare pays $80.00	Medicare pays $80.00
ODM pays $20.00	ODM pays $0.00

Access to Rules and Related Material

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs, and rules; the address is http://www.medicaid.ohio.gov

Most current Medicaid maximum reimbursement amounts are listed in rule 5160-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

(1) Select the 'Medicaid - Provider' folder.
(2) Select 'General Information for Medicaid Providers'.
(3) Select 'General Information for Medicaid Providers (Rules)'.
(4) Select '5160-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

Additional Information

Questions pertaining to this letter should be addressed to:

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