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 31, 2022

Ms. Stephanie McGee Azar, Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, AL 36103-5624

Re: Alabama State Plan Amendment (SPA) 21-0009 – Correction

Dear Commissioner Azar:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) AL 21-0009. This amendment amends the language in the Requirements for Third Party Liability – Payment of Claims with the changes required in the Bipartisan Budget Act (BBA) of 2018 (Pub. L. 115-123) and the Medicaid Services Investment and Accountability Act (MSIAA) of 2019.

During a quality review being conducted by CMS it was discovered that the original approval package sent to Alabama was missing an approved SPA Page. The only update made to the approval package was to add the missing page, Section 4, Page 69(a). AL 21-0009 was approved on February 11, 2022. The enclosed corrected package contains the original signed letter and CMS-179 and all the SPA pages that should have been included in the earlier package.

If you have any questions, please contact Rita Nimmons at (404) 562-7415, or via email at Rita.Nimmons@cms.hhs.gov.

Sincerely,

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Stephanie Lindsay

Table of Contents

State/Territory Name: Alabama

State Plan Amendment (SPA) #: 21-0009

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

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

February 18, 2022

Ms. Stephanie McGee Azar,
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, AL 36103-5624

Re: Alabama State Plan Amendment (SPA) 21-0009 - Correction

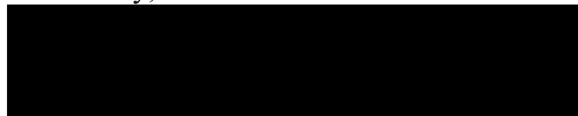
Dear Commissioner Azar:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) AL 21-0009. This amendment amends the language in the Requirements for Third Party Liability – Payment of Claims with changes required in the Bipartisan Budget Act (BBA) of 2018 (Pub. L. 115- 123) and the Medicaid Services Investment and Accountability Act (MSIAA) of 2019.

This letter is to correct an error discovered on the initial State Plan page number that was approved. Please see the attached corrected plan pages. The AL 21-0009 was approved on February 11, 2022, with an effective date of December 1, 2021.

If you have any questions, please contact Rita Nimmons at 404-562-7415 or via email at Rita.Nimmons@cms.hhs.gov.

Sincerely,



James G. Scott, Director
Division of Program Operations

cc: Stephanie Lindsay

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 1 0 0 0 9

2. STATE: A L

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 1, 2021

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 433.139

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2021 $ 0
b. FFY 2022 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Section 4, Page 69a
Attachment 4.22-B, Page 1
Attachment 4.22-B, Page 2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Section 4, Page 69a
Attachment 4.22-B, Page 1

9. SUBJECT OF AMENDMENT

The primary purpose for this amendment is to align Third Party Liability – payment of claims processes with TPL changes required in the Bipartisan Budget Act (BBA) of 2018 (Pub. L. 115- 123) and the Medicaid Services Investment and Accountability Act (MSIAA) of 2019

10. 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: Governor's designee on file via letter with CMS

12. TYPED NAME
Stephanie McGee Azar

13. TITLE
Commissioner

14. DATE SUBMITTED
12·21·21

15. RETURN TO
Stephanie McGee Azar
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

FOR CMS USE ONLY

16. DATE RECEIVED
12/21/21

17. DATE APPROVED 2/11/22

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
December 1, 2021

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

FORM CMS-179 (09/24)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ALABAMA

Requirements for Third Party Liability –
Payment of Claims

The Medicaid Agency's TPL program primarily functions as a cost avoidance system. Claims for medical services, unless excluded by federal law, are cost-avoided when a third party liability policy exists with the Medicaid Agency's claims payment system. Claims paid prior to the identification and input of third party coverage into the claims payment system are pursued by a vendor for post-payment recovery.

Provider compliance with third party billing requirements (42 CFR 433.139(b)(3)(ii)(C)):

The State Plan as referenced herein requires providers to bill liable third party coverage. When a probable third party coverage is established, the Medicaid Agency notifies the provider that the claim was cost-avoided due to the existence of TPL. TPL cost-avoided claims are identified with an Explanation of Benefit Code which provides the third party payer information on the provider's Remittance Advice. Exceptions to the cost-avoidance process:

- claims as specified in 42 CFR 433.139(b)(3)(i),
- when the pursuit of liable third party can result in harm to the beneficiary (Good Cause exemption under 42 CFR 433.147(c)(2)),
- any approved cost-avoidance waiver.

The Medicaid Agency will apply cost-avoidance procedures for prenatal services, including labor, delivery and postpartum care services.

In accordance with 42 CFR 433.139(b)(3)(i), the Medicaid Agency will make payment without regard to potential TPL for pediatric preventive services and will seek recovery from the carrier, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost-avoidance for 90 days. If a provider has billed a third party for pediatric preventive services and has not received a response, the provider will be required to submit proof that at least 90 days has passed from the date of service before the Medicaid Agency will pay the claim.

Where the third party liability is derived from a parent whose obligation to provide medical support is being enforced by the State Title IV-D Agency, providers will be required to bill the third party before filing Medicaid. If a provider has billed a third party and has not received payment, the provider will be required to submit proof that at least 100 days has passed from the date of service before the Medicaid Agency will pay the claim.

Providers are monitored for compliance with insurance billing requirements through post payment recovery by a vendor. If a report of prior payment to either the provider or insured person is received, the amount paid by the carrier is recouped from the provider.

Third Party Collection Procedures to be Cost-Effective:

The Medicaid Agency's MMIS uses a $50 threshold in determining whether to seek recovery from a health insurance carrier for all except drug claims. Claims which do not exceed a paid amount of $50 are placed in an automated suspense file. The suspense file is read monthly to identify recipients whose accumulated claims exceed the threshold. Claims are carried on the suspense file for up to twelve months. The Medicaid Agency's MMIS uses a $25 threshold for drug claims. Drug claims are accumulated monthly for submission to a third party. Accumulated claims which exceed a $25 paid amount are submitted to the third party carrier.

The Medicaid Agency uses a $250 threshold for casualty recovery. Once a liable third party is identified, the entire recipient paid claims history is reviewed. If the accumulated total of paid claims related to the injury third party exceeds $250, recovery is sought from the liable third party.

4.22 Third Party Liability (Continued)

Citation		
42 CFR 433.139 (b) (3) (ii) (A)	X	(c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
		(d) Attachment 4.22-B specifies the following:
42 CFR 433.139(b) (3) (ii) (C)		(1) The method used in determining a provider's compliance with the third party billing requirements at 433.139(b)(3)(ii)(c).
42 CFR 433.139(f)(2)		(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
42 CFR 433.139(f)(3)		(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20		(e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.