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**State/Territory Name: Alaska**

**State Plan Amendment (SPA) #: 22-0005**

This file contains the following documents in the order listed:

**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

August 22, 2022

Adam Crum, Commissioner
Alaska Department of Health
3601 C Street, Suite 902
Anchorage, AK 99503-7167

Re: Alaska State Plan Amendment (SPA) Transmittal Number 22-0005

Dear Mr. Crum:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0005. This amendment updates third-party liability and payment of claims in accordance with requirements in the Bipartisan Budget Act (BBA) of 2018 and the Medicaid Services Investment and Accountability Act (MSIAA) of 2019. Specifically, updating third party liability and related Medicaid payments associated with prenatal care, preventative pediatric services and medical child support.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR § 435.733. This letter is to inform you that Alaska Medicaid SPA 22-0003 was approved on August 19, 2022, with an effective date of July 1, 2022.

If you have any questions, please contact Maria Garza at 206-615-2542 or via email at maria.garza@cms.hhs.gov.

Sincerely,

[redacted]
Digitally signed by James G. Scott -S
Date: 2022.08.22 12:07:30 -05'00'

James G. Scott, Director
Division of Program Operations

cc: Al Wall, Deputy Commissioner, a.wall@alaska.gov
Courtney King, SPA Coordinator, courtney.king@alaska.gov

DEPARTMENT OF HEALTH AND HUMAN 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: 22-0005

2. STATE: AK

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
July 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
Section 1902(a)(25) of the SSA; 42 CFR 433.135 -140

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ (1,370,028)
b. FFY 2023 $ (5,792,481)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
General Administration, pages 69, 69a, 70
Section 4.22-B, pages 1-2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
General Administration, pages 69, 69a, 70
Section 4.22-B, pages 1-~~3 (page 3 deleted from plan)~~ P&I
pages 1-2 P&I

9. SUBJECT OF AMENDMENT
Revision to third-party liability in accordance with the Bipartisan Budget Act of 2018 and the Medicaid Services Investment and Accountability Act 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
/s/

12. TYPED NAME
Albert E. Wall

13. TITLE
Medicaid Director; Deputy Commissioner

14. DATE SUBMITTED
June 30, 2022

15. RETURN TO
Courtney O'Byrne King
Commissioner's Office
3601 C Street, Suite 902
Anchorage, AK 99503

***FOR CMS USE ONLY***

16. DATE RECEIVED
June 30, 2022

17. DATE APPROVED
August 19, 2022

***PLAN APPROVED - ONE COPY ATTACHED***

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]
Digitally signed by James G. Scott -S
Date: 2022.08.22 12:09:00 -05'00'

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

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

22. REMARKS
8.10.22 pen & ink authorized Box 8 reference to page 3 deleted and revised to pages 1-2
8.10.22 Pen & ink to reflect fiscal impact as (savings) Box 6 w/ parenthesis



***Instructions on Back***

Revision: HCFA-PM-94-1 (MB)
February 1994

State/Territory: Alaska

| Citation | 4.22 | Third Party Liability |
|---|---|---|
| 42 CFR §433.137 | | A. The Medicaid agency meets all the requirements of<br>1. 42 CFR 433.138 and 433.139<br>2. 42 CFR 433.145 through 433.148<br>3. 42 CFR 433.151 through 433.154 |
| 1902 (a)(25)(B),(E), (F), (H), and (I) of the Act | | 4. Section 1902 (a)(25)(B), (E), (F), (H), and (I) of the Act |
| 42 CFR §433.138(f) | | B. Attachment 4.22-A<br>1. Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3), and (d)(4), and the diagnosis and trauma code edits required in §433.138(e) conducted; |
| 42 CFR §433.138(g)(1)(ii) and (2)(ii) | | 2. Describes the methods the agency uses for meeting the follow-up requirements contained in §433.138(g)(1)(i) and (g)(2)(i); |
| 42 CFR §433.138(g)(3)(i) and (iii) | | 3. Describes the methods the agency uses for following up on information obtained through the state motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party database and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources; and |
| 42 CFR §433.138(g)(4)(i) through (iii) | | 4. Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party database and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources. |
| 42 CFR §433.139(b)(3)(ii)(A) | ☒ | C. Providers are required to bill liable third parties when furnishing services covered under the plan to an individual on whose behalf the state IV-D agency carries out child support enforcement. |

Revision: HCFA-PM-94-1 (MB)
February 1994

State/Territory: Alaska

4.22 (continued)

D. Attachment 4.22-B specifies the following:

42 CFR §433.139(b)(3)(i) and (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 deciding 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 spe3cified in 42 CFR §447.20.

42 CFR §433.151(a)

F. The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the state as a condition of eligibility for medical assistance with the following:

☒ State title IV-D agency. The state meets the requirements of 42 CFR §433.152(b).

☐ Other appropriate state agency(s)

☐ Other appropriate agencies of another state

☐ Courts and law enforcement officials

1902(a)(60) of the Act

G. The Medicaid agency assures that the state has in effect the laws relating to medical child support under section 1908 of the Act

1906 of the Act

H. The Medicaid agency specifies the guidelines used in determining the cost-effectiveness of an employer-based group health plan by selecting one of the following:

☐ The Secretary's method, as provided in the state Medicaid manual, section 3910.

☒ The state provides methods for determining cost-effectiveness in attachment 4.22-C.

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**Requirements for Third Party Liability Payment of Claims**

Providers of medical services have the primary responsibility for assuring the application of third-party resources to the cost of care before billing Medicaid. Unless excluded by federal law, claims for medical services are cost-avoided when a third-party liability policy exists within the claims payment system. The Medicaid agency applies cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services. The Medicaid agency or its third-party liability (TPL) contractor pursues claims paid before the inclusion of third-party coverage information in the claims system, as described in this attachment.

I. Monitoring Provider Compliance – 42 CFR § 433.139(b)(3)(ii)(C)

A provider submitting a claim for a recipient with a third-party resource must include with the claim an explanation of benefits (EOB) from each known third-party resource. The provider must indicate the amount of payment received from each third-party resource on the claim. If payment was unavailable from a third-party resource, the provider must document the attempt to collect payment by attaching an EOB or other documentation showing denial of payment by the third-party resource.

Exceptions exist for those claims specified in 42 CFR § 433.139(b)(3)(i) and (ii) and any approved cost avoidance waivers. The Medicaid agency monitors provider compliance with insurance billing requirements through post-payment recovery responses to the TPL vendor.

If the provider or the insured person receives a report of prior payment, the amount paid by the insurer is subject to recoupment from the provider.

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

Providers must bill liable third parties when providing services to an individual on whose behalf the Title IV-D agency carries out medical support enforcement unless the provider certifies that before billing Medicaid, the provider (1) billed the third party, (2) waited 100 days from the date of the service provision, and (3) has not received payment from the third-party in compliance with 1902(a)(25)(F) of the SSA.

The state makes payments without regard to potential TPL for pediatric preventive services unless it determines cost-effectiveness and access to care issues warrant cost avoidance for up to 90 days in compliance with 1902(a)(25)(E) of the SSA.

A. Health Insurance

For medical claims paid before the inclusion of the relevant TPL policy information in the eligibility or claims systems, a vendor pursues recovery from the provider within one year of the date of service for amounts greater than $0.01 once combined charges for all recipients from the provider equal or exceed $50.00.

For medical claims with a date of service greater than one year and paid before the inclusion of the relevant TPL policy information in the eligibility or claims systems, a vendor pursues recovery from the liable third-party payor for amounts greater than $0.01 within three years of the date the provider furnished the item or service. Any action by the Medicaid agency to enforce its rights with respect to the claim commences within six years of claim submission.

**Requirements for Third Party Liability Payment of Claims**

B. Casualty Recovery

The threshold for casualty-related claims is $250.00 per individual claim, with no time limit on accumulating outstanding charges.

The Medicaid agency complies with Section 1902(a)(25)(B) of the Social Security Act, using the following factors and guidelines when determining whether or not to pursue recovery of benefits from a liable party after deduction of its proportionate share of attorney's fees and costs.

1. Ascertain the amount of Medicaid lien and the amount of the gross settlement;
2. Determine whether the Medicaid lien plus attorney's fees and costs will exhaust or exceed the settlement funds;
3. If the answer to (b) is yes, and if the Medicaid agency
    a. is informed that the client will not pursue the claim; or
    b. cannot handle the case once it is tendered to the Medicaid agency by the client or the client's attorney to pursue on behalf of the client; or
    c. has made a reasonable effort to ascertain the client's intention regarding the claim but could not obtain a response;

    then the Medicaid agency shall follow the procedure in (4) below.
4. The Medicaid agency shall consider the cost-effectiveness principle in determining the estimated net recovery amount based on the likelihood of collections. The Medicaid agency defines the net recovery amount as recovered dollars applicable to Medicaid costs. In determining the net recovery amount, the Medicaid agency considers the following factors:
    a. The settlement as it may be affected by insurance coverage or other factors relating to the liable party;
    b. The factual and legal issues of liability as they may exist between the client and the liable party;
    c. Any problems of proof in obtaining the award or settlement; and
    d. The estimated attorney's fee and costs as required for the Medicaid agency to pursue the claim.
5. After considering the above factors, the Medicaid agency may pursue a lesser recovery amount to the extent that the Medicaid agency determines it is cost-effective to do so.

III. 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 Medicaid agency are greater than $0.01.

Casualty recovery for personal injury investigative action occurs when hospital bills with trauma diagnoses for which the billed amounts are equal to or greater than $250.00