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**State/Territory Name: Indiana**
**State Plan Amendment (SPA) #: 21-0017**

This file contains the following documents in the order listed:
1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

**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

January 24, 2022

Allison Taylor
Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington Street, Rm W374, MS 07
Indianapolis, IN 46204

Re: Indiana State Plan Amendment (SPA) 21-0017

Dear Ms. Taylor:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number 21-0017. This amendment updates the state plan to comply with the Bipartisan Budget Act of 2018. The modifications are specific to cost avoidance activities for claims that contains prenatal services, including labor and delivery and postpartum care effective December 31, 2021.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR 433.139. This letter is to inform you that Indiana Medicaid SPA 21-0017 was approved on January 24, 2022, with an effective date of December 31, 2021.

If you have any questions, please contact Mai Le-Yuen at 312.353.2853 or via email at mai.le-yuen@cms.hhs.gov.

Sincerely,

Digitally signed by James G. Scott -S
Date: 2022.01.24 14:35:24 -06'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Madison May Gruthusen, FSSA
Keith McConomy, FSSA

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: 21-0017

2. STATE: IN

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 31st, 2021

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR § 433.139

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.22-B Page 1
Attachment 4.22-B Page 2
Page 69, 69a, 70

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.22-B Page 1
Attachment 4.22B Page 2
Page 69, 69a, 70

9. SUBJECT OF AMENDMENT

This State Plan Amendment makes conforming changes to the Medicaid State Plan to bring Indiana Medicaid into compliance with the Bipartisan Budget Act (BBA) of 2018 signed into law by the Centers for Medicare and Medicaid Services (CMS) February 9, 2018. This new legislation requires modifications in coordination of benefits claims processing rules.

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, ASSPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Allison Taylor

13. TITLE
Medicaid Director

14. DATE SUBMITTED
Dec 21st, 2021

15. RETURN TO
Allison Taylor
Medicaid Director:
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, IN 46204
Attn: Madison May Gruthusen, Federal Relations Lead

***FOR CMS USE ONLY***

16. DATE RECEIVED
12/21/21

17. DATE APPROVED
January 24, 2022

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

18. EFFECTIVE DATE OF APPROVED MATERIAL
December 31, 2021

19. SIGNATURE OF APPROVING OFFICIAL
Digitally signed by James G. Scott -S
Date: 2022.01.24 14:35:57 -06'00'

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

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

22. REMARKS

Requirements for Third Party Liability - Payment of Claims

1) The Indiana Medicaid Third Party Liability (TPL) program establishes coordination of benefit rules designed to ensure that Medicaid is the payer of last resort, unless otherwise required. The claims payment system will apply edits that facilitate appropriate cost avoidance/coordination of benefit activities.

   When a third party payor fails to respond within 90 days of the date of the provider's attempt to bill, one of the following attachments must accompany the Medicaid claim:

   a.) copies of unpaid bills sent to the third party (whether an individual or an insurance company);

   b.) written notification from the provider giving the date of attempts to bill and explaining that the third party failed to respond within 90 days from the billing date.

   c.) When the third party payor is an absent parent who has been billed at the address supplied by the recipient of local welfare office, but the billing is returned "address unknown" the returned envelope may be filed with the claim.

   Effective December 31st, 2021 system edits will be updated to require TPL resource validation prior to making payment determinations for claims that contain services for prenatal care including labor and delivery and postpartum care. Applicable claims will be cost avoided accordingly.

   Claims for services relating to pediatric preventative care are excluded from cost avoidance and will follow the pay and chase methodology, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days.

   When coordination of benefits decisions are the result of child support enforcement, claims will not be subject to cost avoidance for up to 100 days following the date the claim has been submitted in accordance with the flexibilities outlined in 1902(a)(25)(F).

2) Health recovery cases are established whenever Medicaid has paid claims in instances where:

   a.) the TPL unit learns of previously unidentified insurance benefits which were available for a period of at least two months prior to the date the benefits are coded on the recipient resource file, and/or

   b.) the TPL Unit is notified that a recipient has insurance coverage for a service for which a paid claim appears on the Medicaid monthly Explanation of Benefits.

      The following threshold applies:

      There is no threshold.

3) Casualty or liability recovery cases are established whenever Medicaid has paid related claims in instances where:

   a.) The TPL Unit is notified that a recipient was a victim of a violent crime or was involved in an accident; and/or

b.) the TPL Unit is notified that a recipient is the plaintiff in a malpractice, product liability, or class action lawsuit involving injury or impairment.

The following threshold applies:

Recovery will be sought in all cases where total Medicaid expenditures exceed $500.00, if it appears it will be cost effective to pursue the case.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994
State/Territory: lndiana

Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:(1) 42 CFR 433.138 and 433,139,
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433,151 through 433.154.
(4) Sections 1902(a)(25)(H) and (I) of the Act,

1902(a)(25)(H) and (I) of the Act

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A --

(1) Specifies the frequency with which the data exchanges required in S433.138(d)(l),(d)(3) and (d) (4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(l)(ii) and (2)(ii)

(2) Describes the methods the agency uses for meeting the follow up requirements contained in S433.138(g)(l)(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 S433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources; and

42 CFR 433,lJS(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 data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third partyresources.

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

Citation State/Territory: Indiana

42 CFR 433.139(b)(3) x (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalfchild support enforcement is being carried outby the State IV-D agency.

Effective December 31, 2021, system edits will be updated to require TPL resource validation prior to making payment determinations for claims that contain services for prenatal care including labor and delivery and postpartum care.

Claims for services relating to pediatric preventative care are excluded from cost avoidance and will follow the pay and chase methodology, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days.

When coordination of benefits decisions are the result of child support enforcement, claims will not be subject to cost avoidance for up to 100 days following the date the claim has been submitted in accordance with the flexibilities outlined in 1902(a)(25)(F).

(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 S433.139(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 deterines 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 isliable follows the restrictions specified in 42 CFR 447.20.

Citation

4.22 (continued)

42 CFR 433.lSl(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: (Check as appropriate.)

_x_ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

_x_ Other appropriate State agency(s)-- State Police, Worker's CompensationDivision of Employment and Training

Other appropriate agency(s} of another State--

_____

_____

1902(a)(60) of the Act

Courts and law enforcement officials.

1906 of the Act

(g) The Medicaid agency assures that the State hasin effect the laws relating to medical child support under section 1908 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.

J The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C4